Anthem Blue Cross **Comparison of In-force Plans to New Anthem Blue Cross PPO**

Benefits	Blue Cross Prudent Buyer Classic In-force		Blue Cross Prudent Buyer Plus In-force		Anthem Blue Cross PPO Effective January 1, 2012	
	Network	Non-Network	Network	Non-Network	Network	Non-Network
Calendar Year Deductible Individual / Family	$100 / Member		$100 / Member		$500 / $1,000	
Annual Out-of-Pocket Maximum Individual / Family	$1,000/ Member	$3,000 / Member	$1,000/Member	$3,000/Member	$3,000 / $6,000	$15,000 / $45,000
Lifetime Maximum Benefit	None		None		None	
Hospital						
Inpatient Services	10%	$250 ded. + 10% (limited to $540/day)	10%	$250 ded. + 10%	20%	40%
Outpatient Surgery	10%	10%	10%	10%	20%	40%
Physician Services						
Physician Office Visit	10%	10%	10%	10%	$20/visit	40%
Periodic Health Exam / Preventive Care	No Charge	Not Covered	No Charge	Not Covered	No Charge	40%
Well Baby Care	No Charge	10%	No Charge	10%	No Charge	40%
Adult Immunization / Inoculation	No Charge	Not Covered	No Charge	Not Covered	No Charge	40%
Diagnostic X-Ray and Lab	10%	10%	10%	10%	20%	40%
Durable Medical Equipment	10%	10%	10%	10%	20%	40%
Ambulance Service	10%	10%	10%	10%	20%	20%
Emergency	10%	10%	10%	10%	$50 ded. + 20% (deductible waived if admitted)	
Mental Health						
Inpatient	10%	10%	10%	10%	20%	40%
Outpatient	10%	10%	10%	10%	20%	40%
Substance Abuse						
Inpatient	10%	10%	10%	10%	20%	40%
Outpatient	10%	10%	10%	10%	20%	40%
Home Health Services	10%	10%	10%	10%	20%	40%
	(Limited 60 visits/cal. year)		(Limited 60 visits/cal. year)		(100 visits/cal. Year)	
Skilled Nursing Facility	10%	10%	10%	10%	20%	40%
	(Up to 100 days/cal. year)		(Up to 100 days/cal. year)		(Up to 100 days/cal. year)	
Occupational Therapy	10%	10%	10%	10%	20%	40%
Physical Therapy	10%	10%	10%	10%	20%	40%
Speech Therapy	10%	10%	10%	10%	20%	40%
Hospice Care	10%	10%	10%	10%	20%	20%
Acupuncture	Not covered		Not covered		20% (12 visits/cal.year & $30/visit max.)	40%
Chiropractic	10%	10%	10%	10%	20% Unlimited	40%
Prescription Drugs	Generic / Brand / Non-Formulary		Generic / Brand / Non-Formulary		Generic / Brand / Non-Formulary	
Retail (30-day supply)	$5 / $10 / $20	$5 / $10 / $20 + 50% of the remaining drug covered expense + costs in excess of the max allowed amt	$5 / $10 / $20	$5 / $10 / $20 + 50% of the remaining drug covered exp + costs in excess of the max allowed amt	$5 / $15 / $30	$5 / $15 / $30 + 50% of the remaining drug covered exp + costs in excess of the max allowed amt
Mail Order (90-day supply)	$10 / $20 / $30	Not Covered	$10 / $20 / $30	Not Covered	$10 / $25 / $45	Not Covered

Note: This is a summary of benefits only and does not include exclusions and limitations.
If there is any discrepancy between this document and the insurance companies' Evidences of Coverage (EOC), the EOC will apply.

8/30/2011