2016/2017 Benefit Coverage Summary

Anthem Medical

www.anthem.com
1-800-324-6086

Anthem Coverage	Network	Non-Network
Calendar Year Deductible		
Per Person	$1,150	$1,500
Per Family	$2,300	$3,000
Co-payments *(Percentage covered after deductible is paid)*	90%	70%
Office Visit	Flat $25	70%
Total Out of Pocket Cost *(Including Deductible and Co-pays Combined)*		
Per Person	$3,000	$5,000
Per Family	$6,000	$10,000
Inpatient Services	10% copay	30% copay
Outpatient Services	10% copay	30% copay
Ambulance	Covered in full Network or Non-Network	
Emergency care in ER Room ***(covers all services, waived if admitted)***	$100 Network or Non-network	
Urgent Care Facility	$50 Network or Non-network	
Lifetime Maximum Limit	Unlimited	

- Pre-authorizations are required for some medical procedures and tests. Always contact Anthem prior to any major medical service to inquire about pre-authorization.
- You do not need to select a primary doctor, but when possible, check to see if medical providers are in-network before receiving service.
- Claim Questions? Contact Anthem or access your account via Anthem website.
- When you receive an EOB (Explanation of Benefits) from Anthem, review it and save for your records during the plan year.
- Misplaced your Anthem ID card? You can get a replacement by contacting Anthem either by phone or requesting one online.
- You may cancel your Anthem medical coverage at any time. However, you may only re-enroll with a status life change or next open enrollment.

Express-Scripts Prescription

www.express-scripts.com
1-800-987-8680

- The co-payment depends on the type and pricing tier of the medication (i.e. generic, preferred brand name, non-preferred brand name). If possible, always ask for a generic brand as that will be the greatest cost savings to you.
- Members **must** use the mail order service for all maintenance medications. Maintenance medications are prescriptions that require more than 3 refills. Members are 100% responsible for the cost of maintenance medications purchased through a retail pharmacy after the 3rd refill.

Express-Scripts	Retail 30 Day Supply	Mail Order 90 Day Supply
Generic	$10.00	$25.00
Preferred Brand Name	$30.00	$75.00
Non-preferred Brand Name	$45.00	$112.50

**Please refer to the Diocese of Gary Website (www.dcgary.org) under the Office of Benefits Section for detailed benefit coverage information.*

*******Voluntary Benefits may only be cancelled during the Annual Open Enrollment Period*******

Anthem Dental *(Voluntary)*

www.anthem.com

Enrollment in the PPO Low Plan or PPO High Plan permits you to see the dentist of your choice either in-network or out-of-network. While you have the option of seeing an out-of-network dentist, you may have to pay more out of pocket. Below are the coverage differences between the two PPO plans.

PPO Low Plan *(Dental Prime In-Network)*		
	In-Network	Out-of-Network
Preventive/Diagnostic Services	100% Coinsurance	50% Coinsurance
Basic Services	80% Coinsurance	50% Coinsurance
Major Services	50% Coinsurance	25% Coinsurance
Orthodontic Services	No Coverage	No Coverage
Deductible per person Deductible family Waiting Period Choice of Dentist	None None None Your choice of any licensed dentist, however using an in-network dentist provides the largest cost savings	$100 3 per family None Your choice of any licensed dentist, however using an in-network dentist provides the largest cost savings
Annual Benefit Maximum	$1,000 per insured person	

PPO High Plan *(Dental Complete In-Network)*		
	In-Network	Out-of- Network
Preventive/Diagnostic Services	100% Coinsurance	80% Coinsurance
Basic Services	50% Coinsurance	50% Coinsurance
Major Services	50% Coinsurance	50% Coinsurance
Orthodontic Services *(Dependent Children Only)*	50% Coinsurance	
Annual Deductible Preventive/Diagnostic	$50; 3 per family Waived	$75; 3 per family Waived
Annual Benefit Maximum	$1,000 per insured person	
Waiting Period	None	

Anthem Vision *(Voluntary)*

www.anthem.com

When using a network provider, enrolled participants and/or eligible dependents are eligible for the following:

Exam	once every 12 months
Lenses	once every 12 months
Frame	once every 24 months
Contacts*	once every 12 months

*(in lieu of frame and lens benefit)

You will receive an ID card in the mail. Blue View Vision also offers additional savings of up to 40% on extra pairs of eyewear, certain non-prescription sunglasses and other popular accessories.

(Blue View Vision Plan In-Network)		
	In-Network	**Out-of-Network**
Co-pays Annual Exam Materials	 $10 $25	 Up to $42 See Below
Frequency Allowance Exam Lenses Frames	 12 12 24	 12 12 24
Lenses Single Bifocal Trifocal Progressive	 100% 100% 100% $90 co-pay/ 100%	 Up to $40 Up to $60 Up to $80 Up to $60
Contacts Elective Med. Necessary	 Up to $130 100%	 Up to $105 Up to $210
Contacts can be replaced every 12 months. The fitting of contact lenses require additional fitting and physician fees. These are the responsibility of the patient.		
Frames	Up to $130	Up to $45
In-network benefits for frames in a store have an internal plan allowance (approximately 75% of stock covered). The patient is responsible for amounts over the allowable.		

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