

2010 Plan Discontinuation

High Level Benefit Comparison – Current vs. New Plan



Your Current Health Plan: PPO 3500 HSA-Compatible (V471, Y368)

New Health Plan Mapped To At Group's Renewal: Lumenos HSA 3500 (80/50) (EF41, EF57)

Below is a high level, side-by-side comparison of one of your current health plans (one that is being discontinued at your group's upcoming renewal) with the most-similar available plan in our portfolio. At your group's renewal, your employees on the discontinuing plan will be transitioned into the new plan listed, unless you (and / or your employee) make alternative plan selections. Please consult this package and your forthcoming Group Renewal Kit for a full description of your plan selection options. Also, a more detailed description of the plan benefits can be found in the Summary of Features for this plan at www.anthem.com/easyrenew or by requesting a copy of the plan's Certificate.

Benefit Category	Current Benefits on PPO 3500 HSA-Compatible Plan	New Benefit Upon Renewal for Lumenos HSA 3500 (80/50) Plan
Annual Deductible In-network & Out-of-network Combined	\$3,500 Single member; \$7,000 Family aggregate. Combined for Medical and Pharmacy.	\$3,500 Single member; \$7,000 Family aggregate. Combined for Medical and Pharmacy.
Annual Out-of-Pocket Maximum In-network	\$4,000 Single member; \$7,500 Family aggregate. Combined for Medical and Pharmacy. In-network & out-of-network combined.	\$5,000 Single member; \$10,000 Family aggregate. Combined for Medical and Pharmacy.
Out-of-network	\$4,000 Single member; \$7,500 Family aggregate. Combined for Medical and Pharmacy. In-network & out-of-network combined.	\$10,000 Single member; \$20,000 Family aggregate. Combined for Medical and Pharmacy.
Office Visits In-network	\$35 copay after annual deductible	20% after annual deductible
Out-of-network	50% of negotiated fee plus 100% of excess charges after annual deductible	50% of negotiated fee plus 100% of excess charges after annual deductible
Professional Services <i>Including maternity, diagnostic lab and x-rays</i> In-network	0% after annual deductible	20% after annual deductible
Out-of-network	50% of negotiated fee plus 100% of excess charges after annual deductible	50% of negotiated fee plus 100% of excess charges after annual deductible
Hospital Inpatient Facility Services In-network	0% after annual deductible	20% after annual deductible
Out-of-network	All charges in excess of \$650 per day after annual deductible	All charges in excess of \$650 per day after annual deductible

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Benefit Category	Current Benefits on PPO 3500 HSA-Compatible Plan	New Benefit Upon Renewal for Lumenos HSA 3500 (80/50) Plan
Outpatient Facility Services In-network Out-of-network	0% after annual deductible All charges in excess of \$380 per day after annual deductible	20% after annual deductible All charges in excess of \$380 per day after annual deductible
Prescription Drugs In-network <i>30-day supply retail</i>	After combined annual medical & pharmacy deductible is met: <i>Generic Drugs: \$10 copay</i> <i>Formulary Brand Drugs: \$25 copay</i> <i>Non-Formulary Brand Drugs: 50%</i> <i>Self-injectable Drugs: 30%</i> After combined annual medical & pharmacy out-of-pocket maximum is met, member responsibility for covered prescription drugs is 0% of negotiated fee	After combined annual medical & pharmacy deductible is met: <i>Generic Drugs: \$10 copay</i> <i>Formulary Brand Drugs: \$30 copay</i> <i>Non-Formulary Brand Drugs: \$50 copay</i> <i>Self-injectable Drugs: 30%</i> After combined annual medical & pharmacy out-of-pocket maximum is met, member responsibility for covered prescription drugs is 0% of negotiated fee
Preventive Care In-network Out-of-network	\$35 copay for office visit (not subject to deductible); 20% for all other covered services after annual deductible. 50% of negotiated fee plus 100% of excess charges after annual deductible	Not subject to annual deductible. 0% of negotiated fee (includes nationally recommended preventive services) 50% of negotiated fee plus 100% of excess charges after annual deductible (includes nationally recommended preventive services)
Annual Preventive Care Options - Physical Exam In-network Out-of-network	Not subject to annual deductible. \$35 copay for office visit; 0% for all other covered services. Maximum Anthem Blue Cross payment of \$200 per year (\$100 if member enrolled less than 6 months) in-network and out-of-network combined. Not subject to annual deductible. 50% of negotiated fee plus 100% of excess charges. Maximum Anthem Blue Cross payment of \$200 per year (\$100 if member enrolled less than 6 months) in-network and out-of-network combined.	Not subject to annual deductible. 0% of negotiated fee (includes nationally recommended preventive services) 50% of negotiated fee plus 100% of excess charges after annual deductible (includes nationally recommended preventive services)