

## Benefit Comparison Charts

The following two charts show some of the benefits that are included in the Standard plans for HMO policies (second chart) and for other policies (first chart). Also shown are benefits included in some non-standardized plans offered by Anthem Blue Cross & Blue Shield and by MEGA Life & Health Insurance Company. Other benefits may be available at an extra premium.

BENEFIT	STANDARD PLAN A	STANDARD PLAN B	ANTHEM HEALTHCHOICE (High Deductible Policy)	DIRIGO CHOICE	MEGA SIGNATURE PLAN (High Deductible Policy)
<b>Deductible</b>	Benefits are paid after the individual <b>or</b> family deductible has been met. The family deductible is met when total expenses paid for all family members exceed <b>two</b> times the individual deductible.			Benefits are paid after the individual <b>or</b> family deductible has been met. The family deductible is met when total expenses paid for all family members exceed <b>two</b> times the individual deductible.	Benefits are paid after the individual <b>or</b> family deductible has been met. The family deductible is met when <b>three</b> family members meet the individual deductible.
<b>Available Deductibles</b>	\$250, \$500, \$1,000, \$1,500 per calendar year.	\$250, \$500, \$1,000, \$1,500 per calendar year.	\$2,250, \$5,000, \$10,000, \$15,000 per calendar year.	Varies by income	\$3,500, \$5,000, \$7,500, \$10,000 per calendar year.
<b>Plan Coinsurance</b>	80% to \$1,000, then 100%	60% to \$1,000, then 100%	None	80% to out-of-pocket limit, which varies by income, then 100%	Choice of 80% to \$2,000, \$5,000 or \$10,000, then 100%; or 50% to \$5,000, \$10,000, or \$20,000, then 100%.

<b>Lifetime Maximum</b>	No limit	No limit	No limit	No limit	No limit
<b>Substance Abuse</b>	<b>Inpatient:</b> calendar year maximum of 30 days. <b>Outpatient:</b> calendar year maximum of \$1,000.	<b>Inpatient:</b> calendar year maximum of 15 days. <b>Outpatient:</b> calendar year maximum of \$500.	<b>Inpatient:</b> 80%; limited to 31 days a year. <b>Outpatient:</b> 50%; limited to 25 visits a year.	Same as physical illness	<b>Not covered</b> unless optional rider is purchased.
<b>Mental Health</b>	<b>Inpatient:</b> 30 day maximum per calendar year. <b>Outpatient:</b> \$1,000 calendar year maximum @ 50% coinsurance.	<b>Inpatient:</b> 15 day maximum per calendar year. <b>Outpatient:</b> \$500 calendar year maximum @ 50% coinsurance.	<b>Inpatient:</b> 80%; maximum 31 days a year. <b>Outpatient:</b> 50%; limited to 25 visits a year.	Listed conditions: Same as physical illness. Non-listed conditions: 80% after \$150 deductible.	<b>Not covered</b> unless optional rider is purchased.
<b>Maternity</b>	Subject to policy deductible and coinsurance.	Subject to policy deductible and coinsurance.	100% after the deductible is met.	Subject to policy deductible and coinsurance.	<b>Not covered</b> , except complications of pregnancy.
<b>Preventive Care</b>	Covered at 100%; no copayment or deductible.	Covered at 100%; no copayment or deductible.	Covered at 100%; no copayment or deductible.	Covered at 100%; no copayment or deductible.	Covered at 100%; no copayment or deductible.
<b>Chiropractic Care</b>	36 visits per calendar year; subject to policy deductible and coinsurance.	18 visits per calendar year; subject to policy deductible and coinsurance.	100% after the deductible is met; limit of 25 manipulations per calendar year.	40 visits per calendar year; subject to policy deductible and coinsurance.	Subject to policy deductible and coinsurance.

<b>Prescriptions</b>	Subject to policy deductible and coinsurance.	No deductible or coinsurance. Co-payment of \$20 for generic drugs and \$30 for brand name drugs.	100% after the deductible is met.	No deductible or coinsurance. Co-pay of \$10 for generic, \$25 for brand name, and \$40 for optional brand name drugs.	<b>Not covered</b>
<b>Emergency Room Care</b>	Subject to \$50 co-pay if not confined to the hospital. Subject to policy deductible and coinsurance.	Subject to \$75 co-pay if not confined to the hospital. Subject to policy deductible and coinsurance.	100% after the deductible is met.	Subject to policy deductible and coinsurance.	Only for emergency medical condition. Subject to copay of \$250 or \$500 and policy deductible and coinsurance. Deductible waived if optional rider purchased.
<b>Inpatient Hospital Services</b>	Subject to policy deductible and coinsurance. No limit on number of days.	Subject to policy deductible and coinsurance; limited to 60 days per calendar year.	100% after the deductible is met. No limit on number of days.	Subject to policy deductible and coinsurance. No limit on number of days.	Subject to policy deductible and coinsurance. No limit on number of days.
<b>Outpatient Surgical Facility</b>	Subject to policy deductible and coinsurance.	Subject to policy deductible and coinsurance.	100% after the deductible is met.	Subject to policy deductible and coinsurance.	Subject to policy deductible and coinsurance.
<b>Surgeon</b>	Subject to policy deductible and coinsurance.	Subject to policy deductible and coinsurance.	100% after the deductible is met.	Subject to policy deductible and coinsurance.	Subject to policy deductible and coinsurance.
<b>Ambulance</b>	Subject to policy deductible and coinsurance.	Subject to policy deductible and coinsurance.	100% after the deductible is met.	Subject to policy deductible and coinsurance.	Subject to policy deductible and coinsurance.
<b>Physician's Care While Hospitalized</b>	Covered subject to the policy deductible and coinsurance.	Covered subject to the policy deductible and coinsurance.	100% after the deductible is met.	Subject to policy deductible and coinsurance.	Inpatient doctor visits limited to one per day.

<b>Physician's Office Visits</b>	Covered subject to the policy deductible and coinsurance.	Covered subject to the policy deductible and coinsurance.	100% after the deductible is met.	100% after \$20 copayment. Deductible does not apply.	<b>Not covered</b> unless optional rider is purchased.
<b>Skilled Nursing Care</b>	100 days per calendar year.	<b>Not covered.</b>	100% after the deductible is met; limit 365 days (calendar year).	100 days per calendar year; subject to policy deductible and coinsurance.	<b>Not covered.</b>
<b>Home Health Care</b>	100 visits per calendar year; covered at 80%.	100 visits per calendar year; covered at 60%.	100% after the deductible is met; limit 90 visits per calendar year.	Subject to policy deductible and coinsurance.	Subject to the policy deductible and coinsurance.

<b>BENEFIT</b>	<b>HMO STANDARD PLAN A (Offered by HMOs)</b>	<b>HMO STANDARD PLAN B (Offered by HMOs)</b>
<b>Deductible</b>	Not applicable	Not applicable
<b>Plan Coinsurance</b>	Not applicable	<b>Inpatient</b> only: 80% to \$2,000 then 100%
<b>Lifetime Maximum</b>	Not applicable	Not applicable
<b>Substance Abuse</b>	No lifetime maximum. <b>Inpatient:</b> 30 day calendar year maximum. <b>Outpatient:</b> \$1,000 per calendar year; \$10 copayment per visit.	No lifetime maximum. <b>Inpatient:</b> 15 day calendar year maximum. <b>Outpatient:</b> \$500 calendar year; \$25 copayment per visit.
<b>Mental Health</b>	No lifetime maximum. <b>Inpatient:</b> 30 day calendar year maximum.	No lifetime maximum. <b>Inpatient:</b> 15 day calendar year maximum.

	<b>Outpatient:</b> \$1,000 per calendar year; \$10 copayment per visit.	<b>Outpatient:</b> \$500 per calendar year; \$25 copayment per visit.
<b>Preventive Care</b>	Covered expenses are payable at 100%.	Covered expenses are payable at 100%.
<b>Chiropractic Care</b>	Subject to \$10 co-payment per visit.	Subject to \$15 co-payment per visit.
<b>Prescriptions</b>	\$10 co-pay for generic drug and \$20 co-pay for brand name drugs.	\$20 co-pay for generic drug and \$30 co-pay for brand name drugs.
<b>Emergency Room Care</b>	Subject to \$50 co-pay if not confined to the hospital.	Subject to \$150 co-pay if not confined to the hospital.
<b>Inpatient Hospital Services</b>	No limit on number of days. \$250 co-payment per day for first 5 days per year.	60 days per calendar year. \$250 co-payment per day. Coinsurance: 80% to \$2,000, then 100%.
<b>Physician's Care</b>	Subject to \$10 co-payment for office visits.	Subject to \$25 co-payment for office visits.
<b>Skilled Nursing Care</b>	100 days per calendar year; \$25 co-payment per day.	<b>Not covered.</b>
<b>Home Health Care</b>	100 visits per calendar year; \$10 co-payment per visit.	100 visits per calendar year; \$25 co-payment per visit.