



BENEFIT SUMMARY

POS High Deductible Health Plan - Indiana

***** Vanderburgh County *****

~ January 1, 2012 - December 31, 2012 ~

**Plan 4
(Dual/SS/MP/HDHP)**

The Benefit Summary indicates WHP benefits, Member Copays, Coinsurance and Deductibles. The entire provisions of benefits and exclusions are contained in the Employer and Member Agreement. In the event of a conflict between the Agreement and this summary description, the terms of the Agreement will prevail.

CUSTOMER SERVICE DEPARTMENT

(812) 426-6600 ♦ (800) 521-0265

GENERAL BENEFIT LIMITS	IN-PLAN	OUT-OF-PLAN
Benefit Limit Per Lifetime <i>(Excluding Organ & Tissue Transplants)</i>		UNLIMITED <i>(limited to \$1,250,000 per contract year)</i>
Deductible Per Calendar Year		\$2,500/person \$5,000/family
Out-of-Pocket Maximum Per Calendar Year <i>(Deductible applies to Out-of-Pocket Maximum)</i>		\$5,250/person ¹ \$10,500/family
Prior Authorization	Participating Provider Responsibility	Member responsibility ² (See explanation below)
Claims	Participating Providers submit claims	Member responsibility submit to WHP within 90 days
Excess Charges	None – Participating Providers accept WHP's Usual & Customary Fees	Member is responsible ³ for charges exceeding WHP's Usual & Customary Fees
Pre-Existing Conditions	Not applicable	Not applicable

before WHP pays any medical benefits during a calendar year. If abnormality/ies is encountered or a preexisting problem is addressed in the process of performing this preventive medicine service, that service may be separately billed (*Section 3, Member Certificate*).

♦ **Preventive Care Services include (Covered at 100% In-Plan):**

- | | | |
|---------------------------|------------------------------------|---------------------------|
| - an annual physical exam | - screening mammograms | - routine lab and x-ray |
| - routine immunizations | - preventive colonoscopy screening | associated with an annual |
| - routine pap smears | - prostate screening | physical exam |

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PHYSICIAN OFFICE (PCP/REFERRED SPECIALIST)	IN-PLAN	OUT-OF-PLAN
Office Visits to PCP, PA or NP..... <i>PA - Physician Assistant, NP - Certified Nurse Practitioner</i>	100% Coverage after Deductible	80% Coverage after Deductible
Office Visits to Specialist, PA or NP..... <i>PA - Physician Assistant, NP - Certified Nurse Practitioner</i>	100% Coverage after Deductible	80% Coverage after Deductible
Preventive Care ♦.....	100% Coverage	80% Coverage after Deductible
Allergy Injections.....	100% Coverage after Deductible	80% Coverage after Deductible
Immunizations & Injectable Medications.....	100% Coverage after Deductible	80% Coverage after Deductible
Durable Medical Equipment & Medical Supplies.....	100% Coverage after Deductible	80% Coverage after Deductible
Laboratory, X-Ray & Other Diagnostic Services.....	100% Coverage after Deductible	80% Coverage after Deductible
Ambulatory Surgery.....	100% Coverage after Deductible	80% Coverage after Deductible
Chiropractic Services (<i>Maximum Benefit Per Contract Year = \$750</i>)	100% Coverage after Deductible	80% Coverage after Deductible
Selected Benign Lesion Removal.....	50% Coverage after Deductible	Not Covered
EMERGENCY/URGENT CARE⁴	IN-PLAN	OUT-OF-PLAN
Emergency Room (ER) Services.....	100% Coverage after Deductible	Covered under IN-PLAN Benefits
Urgent Care Center		
• Out-of-Area.....	N/A	100% Coverage after Deductible
• In-Area.....	100% Coverage after Deductible	80% Coverage after Deductible
Ambulance Services (If Medically Necessary)		
• Ground Transportation.....	100% Coverage after Deductible	Covered under IN-PLAN Benefits
• Air/Water Transportation.....	100% Coverage after Deductible	Covered under IN-PLAN Benefits

⁴Emergency and Out-of-Area Urgent Care is Covered anywhere. Members must notify WHP within 48 hours. In-Area Urgent Care is Covered through the Member's PCP. ER Copay is waived if Member is hospitalized as an inpatient from ER.

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INPATIENT (HOSPITAL & OTHER PROVIDERS)	IN-PLAN	OUT-OF-PLAN
Hospital: Semi-Private Room and Ancillary Services.....	100% Coverage after Deductible	80% Coverage after Deductible
Physician, PA and NP Services..... <i>PA - Physician Assistant, NP - Certified Nurse Practitioner</i>	100% Coverage after Deductible	80% Coverage after Deductible
Alcohol and Drug Detoxification.....	100% Coverage after Deductible	80% Coverage after Deductible
Skilled Nursing Facility (SNF) Services..... <i>Maximum SNF Benefit Per Condition = 100 Days</i>	100% Coverage after Deductible	80% Coverage after Deductible
OUTPATIENT (HOSPITAL & OTHER PROVIDERS)	IN-PLAN	OUT-OF-PLAN
Hospital and Other Facility Services..... <i>(includes screening colonoscopy)</i>	100% Coverage after Deductible	80% Coverage after Deductible
Physician, PA and NP Services..... <i>PA - Physician Assistant, NP - Certified Nurse Practitioner</i>	100% Coverage after Deductible	80% Coverage after Deductible
Laboratory, X-Ray & Other Diagnostic Services..... <i>(includes mammography)</i>	100% Coverage after Deductible	80% Coverage after Deductible
Selected Benign Lesion Removal.....	50% Coverage after Deductible	Not Covered
Alcohol and Drug Detoxification.....	100% Coverage after Deductible	80% Coverage after Deductible
Durable Medical Equipment and Medical Supplies.....	100% Coverage after Deductible	80% Coverage after Deductible
Radiation Therapy Services.....	100% Coverage after Deductible	80% Coverage after Deductible
Rehabilitation Therapy Services:		
♦ Physical and Occupational..... <i>Physical and Occupational Therapy is limited to a maximum of 40 combined visits per contract year</i>	100% Coverage after Deductible	80% Coverage after Deductible
♦ Speech..... <i>Speech Therapy is limited to a maximum of 20 visits per contract year</i>	100% Coverage after Deductible	80% Coverage after Deductible
♦ Cardiac and Pulmonary Rehab..... <i>Cardiac and Pulmonary Rehab Therapy is limited to a maximum of 24 visits each per contract year</i>	100% Coverage after Deductible	80% Coverage after Deductible
Skilled Home Health and Hospice Services.....	100% Coverage after Deductible	80% Coverage after Deductible

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RIDERS (only if applicable)

For a detailed description of Covered Services, refer to the applicable Rider.

RIDER 1: PRESCRIPTION DRUGS

Copayments apply only after the deductible is met.
 Copayments apply to the maximum out-of-pocket.

	Level 1	Level 2	Level 3
Standard 30 day supply/refill			
-Copay	\$10	\$25	\$40
31-90 day supply			
-Copay	\$20	\$50	\$80

The Deductible is waived for Selected Preventive Generic drugs and medications, so the applicable Copay level stated above will apply. Once the annual Deductible is satisfied, all other Prescription drugs will also have the Copays indicated in the table.

Some drugs may require prior authorization and may have quantity limits. Please see your Agreement and the Selected Pharmaceutical List (SPL) for additional information. A \$0 copay would apply to all diabetic and asthma supplies written on a prescription and obtained from a participating pharmacy. Pharmacy must dispense as written. If generic is available and Member or Physician requests brand, Member is not responsible for applicable brand Copay and/or the difference in cost between brand and generic drug.

RIDER 4: ORGAN AND TISSUE TRANSPLANTS

	IN-PLAN	OUT-OF-PLAN
Organ & Tissue Transplant Services.....	100% Coverage after Deductible	Not Covered
Transportation and Lodging.....	Coverage up to \$10,000	Not Covered
<i>Maximum Benefit Per Member Per Contract Year = \$1,000,000</i>		
<i>Medical Director approval is req'd prior to receiving any Transplant service.</i>		
<i>Member Coinsurance for Organ and Tissue Transplant services applies to Out-of-Pocket Maximum</i>		

RIDER 5: MENTAL HEALTH/CHEMICAL DEPENDENCY

	IN-PLAN	OUT-OF-PLAN
Mental Health		
Inpatient Professional and Facility.....	100% Coverage after Deductible	80% Coverage after Deductible
Outpatient Professional and Facility.....	100% Coverage after Deductible	80% Coverage after Deductible
Individual or Group Therapy Office Visits.....	100% Coverage after Deductible	80% Coverage after Deductible
Chemical Dependency		
Inpatient Professional and Facility.....	100% Coverage after Deductible	80% Coverage after Deductible
Outpatient Professional and Facility.....	100% Coverage after Deductible	80% Coverage after Deductible
Individual Therapy Office Visits.....	100% Coverage after Deductible	80% Coverage after Deductible
Group Therapy Office Visits.....	100% Coverage after Deductible	80% Coverage after Deductible

Member Coinsurance for Mental Health/Chemical Dependency services applies to Out-of-Pocket Maximum

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RIDER 8: INFERTILITY	IN-PLAN	OUT-OF-PLAN
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Selected Inpatient and Outpatient Services:		
♦ Professional and Facility.....	50% Coverage after Deductible	Not Covered
♦ Selected Infertility Drugs.....	50% Coverage after Deductible	Not Covered
<i>Member Coinsurance for Infertility services does not apply to Out-of-Pocket Maximum</i>		

RIDER 10: MATERNITY SERVICES	IN-PLAN	OUT-OF-PLAN
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Inpatient Professional Services.....	100% Coverage after Deductible	80% Coverage after Deductible
Inpatient Facility Services.....	100% Coverage after Deductible	80% Coverage after Deductible
Outpatient Professional Services.....	100% Coverage after Deductible	80% Coverage after Deductible
Outpatient Facility Services.....	100% Coverage after Deductible	80% Coverage after Deductible
Office Visit to PCP, PA or NP..... <i>PA - Physician Assistant, NP - Certified Nurse Practitioner</i>	100% Coverage after Deductible	80% Coverage after Deductible
Office Visit to Specialist, PA or NP..... <i>PA - Physician Assistant, NP - Certified Nurse Practitioner</i>	100% Coverage after Deductible	80% Coverage after Deductible
<i>Member Coinsurance for Maternity services applies to Out-of-Pocket Maximum</i>		