

## Some definitions – so we’re all on the same page.

A **premium** is the amount of money you pay on a regular basis – once a month, four times a year, twice a year or once a year – to your insurance company to keep your health plan active. You can’t apply what you pay for your premium toward your deductible.

A **deductible** is the amount of out-of-pocket expenses you have to pay each year before your health plan kicks in and starts paying for services.

A **copayment** is a specified dollar amount or percentage of money you have to pay out of your own pocket for covered services.

A **coinsurance level** is the percentage of money you have to pay out of your own pocket for covered services. It’s the portion of the bill not paid by your health plan after the deductibles have been reached.

An **out-of-pocket limit** is the total amount of money (not counting your premiums) you have to pay each year for your healthcare coverage. Your deductible and coinsurance payments for covered services count toward your out-of-pocket limit.

A **discount** is the reduced out-of-pocket cost you enjoy when you obtain healthcare services from a network provider.

A **drug formulary** is a list of brand-name and generic medications that have been rigorously reviewed and selected by a committee of practicing doctors and clinical pharmacists for their quality and effectiveness. You may help control the amount you pay for prescriptions by encouraging your doctor to prescribe medications from the Anthem formulary on our website at [www.anthem.com](http://www.anthem.com).



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K E N T U C K Y

Individual

# Blue Access<sup>®</sup> Value

PLAN BENEFITS GUIDE

Si necesita asistencia en español, usted puede solicitarla sin costo adicional contactando a su corredor o agente de cuidados de la salud. También puede visitar [www.anthem.com/espanol](http://www.anthem.com/espanol).

## BLUE ACCESS VALUE

	NETWORK YOU PAY		NON-NETWORK YOU PAY	
	Individual	Family	Individual	Family
<b>Calendar-year deductible</b>	\$ 2,000	\$ 4,000	\$ 4,000	\$ 8,000
	\$ 3,000	\$ 6,000	\$ 6,000	\$ 12,000
	\$ 5,000	\$ 10,000	\$ 10,000	\$ 20,000
	\$ 10,000	\$ 20,000	\$ 20,000	\$ 40,000
<b>Out-of-Pocket Maximum</b> <i>(including deductible)</i>	Individual	Family	Individual	Family
	\$ 5,000	\$ 10,000	\$ 10,000	\$ 20,000
	\$ 6,000	\$ 12,000	\$ 12,000	\$ 24,000
	\$ 8,000	\$ 16,000	\$ 16,000	\$ 32,000
	\$ 13,000	\$ 26,000	\$ 26,000	\$ 52,000
<b>Physician Office Services</b> <i>All medical office visits including office visits associated with a routine pap smear, annual mammogram, colorectal cancer screening or PSA screening.</i>	Visits 1 and 2, member pays \$30 copayment <sup>2,3</sup> The deductible does not apply to these office visits (copayment applies to office charge only). Other covered office services subject to deductible and 30% coinsurance. Visits 3+ are not covered.		Visits 1 and 2, member pays 40% coinsurance <sup>3</sup> The deductible does not apply to these office visits. Other covered office services subject to deductible and 40% coinsurance. Visits 3+ are not covered.	
<b>Preventive Care</b>	30% <sup>1</sup>		40% <sup>1</sup>	
<i>NOTE: Lab/X-Ray for routine Pap smear, annual mammogram, colorectal cancer screening or PSA screening ONLY. Other preventive care services are not covered.</i>				
<b>Well Child Care</b>	Not Covered		Not Covered	
<b>Diagnostic Services</b>	30% (not subject to deductible)		40% (not subject to deductible)	
<i>NOTE: \$300 maximum per member, per calendar-year, network and non-network combined (Includes lab work, X-rays, and Outpatient Diagnostic Services. Preventive services are excluded from the \$300 limit).</i>				
<b>Inpatient Hospital Services</b>	30% <sup>1</sup>		40% <sup>1</sup>	
<b>Outpatient Services</b>	30% <sup>1</sup>		40% <sup>1</sup>	
<b>Emergency Room</b>	30% <sup>1</sup> (additional \$60 copayment if not admitted <sup>2</sup> )		30% <sup>1</sup> (additional \$60 copayment if not admitted <sup>2</sup> )	
<b>Urgent Care</b>	30% <sup>1</sup>		30% <sup>1</sup>	
<b>Ambulance (includes air)</b>	30% <sup>1</sup>		30% <sup>1</sup>	
<b>Maternity Services</b>	Not Covered		Not Covered	
<b>Outpatient Therapy Services</b>	Not Covered		Not Covered	

## BLUE ACCESS VALUE (CONTINUED)



	NETWORK YOU PAY	NON-NETWORK YOU PAY
<b>Mental Health and Substance Abuse Inpatient</b>	30% <sup>1</sup>	40% <sup>1</sup>
Inpatient Mental Health Services - Limited to 10 days per calendar year (includes both Network and Non-network combined. Also includes Network Substance Abuse).		
Inpatient Substance Abuse Services - Limited to 10 days per calendar year (includes Mental Health Services). Limited to \$550 combined maximum for Non-network Inpatient and Outpatient Substance Abuse Services.		
<b>Mental Health and Substance Abuse Outpatient</b>	30% <sup>1</sup>	40% <sup>1</sup>
Outpatient Mental Health Services - Limited to 10 visits per calendar year (includes both Network and Non-network combined. Also includes Network Substance Abuse).		
Outpatient Substance Abuse Services - Limited to 10 visits per calendar year (includes Mental Health Services. Limited to \$550 combined maximum for Non-network Inpatient and Outpatient Substance Abuse Services).		
<b>Mental Health and Substance Abuse Physician Office Visit &amp; Examination</b> <i>(Limit 2 visits per calendar year, combined with physician office visit limit for medical services)</i>	Visits 1 and 2, member pays \$30 <sup>2,3</sup> copayment, no deductible. Visits 3+ not covered	Visits 1 and 2, member pays 40% <sup>3</sup> copayment, no deductible. Visits 3+ not covered
<b>OPTIONAL - Extended Mental Health Rider</b> <i>NOTE: Mental health treated same as any other condition (Limit 2 visits per calendar year, combined with physician office visit limit for medical services)</i>	Office Visit - Visits 1 and 2, member pays \$30 <sup>2,3</sup> copayment, no deductible. Visits 3+ - Not Covered. Other Services - 30% <sup>1</sup>	Office Visit - Visits 1 and 2, member pays 40% <sup>3</sup> coinsurance, no deductible. Visits 3+ - member pays 100% of billed charges. The 2 office visits are combined for participating and non-participating providers. Coverage is limited to 2 office visits per calendar year. Other Services - 40% <sup>1</sup>

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<sup>1</sup> Services subject to calendar year deductible. Network and non-network deductibles accumulate towards each other.

<sup>2</sup> Copayment does not apply to deductible or out-of-pocket maximum.

<sup>3</sup> Physician office visits and mental health office visits are combined for a maximum of 2 visits per person, per calendar year. Subsequent office visits are not covered.

	NETWORK YOU PAY	NON-NETWORK YOU PAY
<b>Home Health Care</b> <i>(Maximum visits per benefit period - 60 visits)</i>	30% <sup>1</sup>	40% <sup>1</sup>
<b>Hospice</b>	0% <sup>1</sup> (not subject to deductible)	0% <sup>1</sup> (not subject to deductible)
<b>Durable Medical Equipment Prosthetic Devices</b> <i>(\$4,000 maximum per benefit period)</i>	Not Covered 30% <sup>1</sup>	Not Covered 40% <sup>1</sup>
<b>Human Organ and Tissue Transplant Services</b>	30% <sup>1</sup>	40% <sup>1</sup> (coinsurance does not apply to out-of-pocket maximum)
<b>Plan Lifetime Maximum</b>	\$7,000,000 maximum per member for Network and Non-network services combined.	
<b>Preexisting Waiting Period</b>	12 months	12 months

<sup>1</sup> Services subject to calendar year deductible. Network and non-network deductibles accumulate towards each other.

**This Blue Access Value Plan Benefits Guide is intended to be a brief outline of coverage and is not intended to be a legal contract. The entire provisions of benefits and exclusions are contained in the contract or certificate of coverage. In the event of a conflict between the contract or certificate of coverage and this Blue Access Value Plan Benefits Guide, the terms of the contract or certificate of coverage will prevail.**

## PRESCRIPTION DRUG BENEFITS

NETWORK YOU PAY	NON-NETWORK YOU PAY
<b>Retail (30-day supply):</b> <ul style="list-style-type: none"> <li>Generic Formulary - \$10 per prescription<sup>2</sup></li> <li>Brand-name Formulary - \$200 deductible per member, per calendar year, then \$25 copay per prescription.<sup>2</sup></li> <li>Generic Non-formulary - \$10 per prescription<sup>2</sup></li> <li>Brand-name Non-formulary - Not covered</li> </ul>	<b>Retail (30-day supply):</b> <ul style="list-style-type: none"> <li>Generic Formulary - Not covered</li> <li>Brand-name Formulary - Not covered</li> <li>Generic Non-formulary - Not covered</li> <li>Brand-name Non-formulary - Not covered</li> </ul>
<b>Mail Service (90-day supply):</b> <ul style="list-style-type: none"> <li>Generic Formulary - \$20 per prescription<sup>2</sup></li> <li>Brand-name Formulary - \$200 deductible per member, per calendar year, then \$50 copay per prescription.<sup>2</sup></li> <li>Generic Non-formulary - Not covered</li> <li>Brand-name Non-formulary - Not covered</li> </ul>	<b>Mail Service (90-day supply):</b> <ul style="list-style-type: none"> <li>Generic Formulary - Not covered</li> <li>Brand-name Formulary - Not covered</li> <li>Generic Non-formulary - Not covered</li> <li>Brand-name Non-formulary - Not covered</li> </ul>

*NOTE: Anthem pays \$500 maximum per person, per calendar year, for both retail and mail service combined.*

**Generic prescription drug benefits are not subject to deductible.**

**Specialty Drugs** - Specialty Drugs are high cost, scientifically engineered drugs. They are usually injected or infused and require special storage and handling that make them difficult for a typical pharmacy to dispense. Specialty Drugs must be obtained through our Specialty Pharmacy network in order to receive network level benefits.

Mail order and prescription drug benefits administered by WellPoint NextRx.

<sup>2</sup> Copayment does not apply to deductible or out-of-pocket maximum.

## And now – some really important legal information you should take the time to read.

### Who can apply.

You can apply for coverage for yourself or with your family. Family health coverage includes you, your spouse or domestic partner and any dependent children. Children are covered to the end of the month in which they turn 25. You must be a resident of the state in which you are applying, a legal resident of the U.S. and not currently pregnant.

### What's a preexisting condition?

Blue Access Value covers preexisting conditions after you've been enrolled in the plan for 12 months. A preexisting condition is any medical or physical condition you had in the six months right before you enrolled. If you received medical advice, a diagnosis, care or treatment for the condition – or if it was recommended that you do so – that qualifies it as “preexisting”.

### What we do not cover.

Blue Access Value plans don't provide benefits for services, supplies or charges having to do with preexisting conditions (see “What's a preexisting condition?”); private duty nursing; maternity services; experimental or investigative treatment; dental and vision, except as spelled out in your contract; charges greater than the maximum allowable amount (charges exceeding the amount Anthem recognizes for services); care provided by a member of your family; treatment that's primarily intended to improve your appearance; weight loss programs or treatment of obesity; hearing aids; eyeglasses or contact lenses; radial keratotomy or keratomileusis or excimer laser photo; artificial insemination, fertilization, infertility drugs or sterilization reversal; sex transformation surgery;

custodial care; artificial and mechanical hearts; workers' compensation; and services we determine aren't medically necessary.

These are some of the exclusions contained in the plans. Check your contract or certificate of coverage for a complete listing of benefits, exclusions and maximum payment levels.

### Our appeal rights and confidentiality policy.

If we deny a claim or request for benefits completely or partially, we will notify you in writing. The notice will explain why we denied the claim/request and describe the appeals process. You can appeal decisions that deny or reduce benefits. We encourage you to file appeals right away when you first get an initial decision from us, but we require that you file within six months of getting one. You should send additional information that supports your appeal and state all the reasons why you feel the appeal request should be granted. We will review your appeal and let you know our decision in writing within 30 days of receiving your first appeal.

If you are denied coverage based on medical necessity or experimental/investigative exclusions, you can request that a board-eligible or board-certified specialist review your appeal. If we deny coverage for reasons other than medical necessity or experimental/ investigative reasons, you can also appeal.

Please call customer service or check your contract or certificate of coverage for more information on our internal appeal and external review processes. Unless our notice of decision

includes a different address, send requests for a review of appeal to:

**Anthem Blue Cross and Blue Shield  
Appeals Coordinator  
P.O. Box 33200  
Louisville, KY 40232-3200**

If we uphold our decision throughout the appeals process, you can request a review by the Kentucky Office of Insurance. In addition to the appeals processes we just described, Anthem has adopted a confidentiality policy in Kentucky. This policy includes guidelines regarding the protection of confidential member information and a member's right to access and change information in Anthem's possession. The policy clearly points out when a member needs to sign a release before Anthem can disclose information to a member's provider, spouse or other family members.

### We want you to be satisfied.

If you aren't satisfied with your Blue Access Value coverage, you can cancel it within 30 days after you receive your contract or certificate of coverage or have access to it online, whichever is earlier. If you haven't submitted any claims, you'll get a full refund of the premium you paid when coverage is cancelled within the first 30 days. You can view your contract or certificate of coverage online or receive a paper copy of it upon request as outlined in your initial membership letter.

## Information about our Network Providers.

### Using our network.

To be eligible to receive the maximum benefits available, you must use network providers. (Please refer to your provider directory, located on [www.anthem.com](http://www.anthem.com), for a list of network providers.)

### Notice of provider arrangements.

Your Participating Provider's agreement for providing covered services may include financial incentives or risk-sharing relationships which are based on utilization and quality of services. If you have any questions regarding such incentives or risk-sharing relationships, please contact Anthem or your provider.

### Any willing provider.

If a non-network provider meets our enrollment criteria and is willing to meet the terms and conditions for participation, that provider has the right to apply to become a network provider for the products associated with this product brochure.

### Accessing Covered Services.

Some services, or supplies, such as prescription drugs, require your doctor to receive an authorization from Anthem that defines and/or limits the conditions under which the service, or supply, will be covered to help you avoid any unnecessary out-of-pocket expenses. Other services, such as organ transplants, require your physician to certify, and for us to approve the service as medically necessary and the appropriate setting. Neither process is a guarantee of coverage.

### Non-network provider.

If you receive covered services from a non-network provider, you are responsible for the difference between the actual charge billed and the maximum allowable amount plus any deductible, copayments and non-covered charges.

### Customary waiting times.

The standard waiting time for routine care is two weeks and urgent care is 48 hours. These waiting times are standard only and may not be indicative of the amount of time you wait for routine or urgent care.