Anthem

KENTUCKY

Individual

Blue Access® 1, 2, 3

Sí 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.

PLAN BENEFITS GUIDE

Calendar-year deductible

Out-of-Pocket Maximum (including deductible)

Non-network Penalty

Physician Office Services

Preventive Care

Well Child Care

Diagnostic Services

Inpatient Hospital Services

Outpatient Services

Emergency Room

Urgent Care (in Urgent Care Center)

Ambulance (includes air)

Maternity Services

Outpatient Therapy Services
Maximum visits per benefit period for Network and Non-network combined:
- Physical Therapy and Manipulation Therapy - 20 visits maximum
- Speech Therapy - 20 visits maximum
- Occupational Therapy - 20 visits maximum

Mental Health - Inpatient and outpatient substance abuse rehabilitation programs are limited to two per lifetime. Inpatient mental health and substance abuse services Benefit period maximums - 10 days (Network and Non-network combined); Benefit period maximums - 10 visits (Network and Non-network combined); $550 combined maximum for Non-network inpatient and outpatient substance abuse). Autism- therapeutic, respite and rehabilitation care ($500 per month for children ages 2-21)

Home Health Care (Maximum visits per benefit period - 60 visits)

Hospice

Durable Medical Equipment ($4,000 maximum per benefit period)
Prosthetic Devices ($4,000 maximum per benefit period)

Human Organ and Tissue Transplant Services (for kidney and cornea transplants, services covered same as any other illness under Medical)

Transportation, Lodging and Meals

Plan Lifetime Maximum

Preexisting Waiting Period

PLAN 1		PLAN 2	
NETWORK YOU PAY	NON-NETWORK YOU PAY	NETWORK YOU PAY	NON-NETWORK YOU PAY
$500 individual / $1,000 family $1,000 individual / $2,000 family $2,500 individual / $5,000 family $5,000 individual / $10,000 family	$1,000 individual / $2,000 family $2,000 individual / $4,000 family $5,000 individual / $10,000 family $10,000 individual / $20,000 family	$250 individual / $500 family $500 individual / $1,000 family $1,000 individual / $2,000 family $2,500 individual / $5,000 family	$500 individual / $1,000 family $1,000 individual / $2,000 family $2,000 individual / $4,000 family $5,000 individual / $10,000 family
$2,500 individual / $5,000 family $3,000 individual / $6,000 family $4,500 individual / $9,000 family $7,000 individual / $14,000 family	$5,000 individual / $10,000 family $6,000 individual / $12,000 family $9,000 individual / $18,000 family $14,000 individual / $28,000 family	$2,250 individual / $4,500 family $2,500 individual / $5,000 family $3,000 individual / $6,000 family $4,500 individual / $9,000 family	$4,500 individual / $9,000 family $5,000 individual / $10,000 family $6,000 individual / $12,000 family $9,000 individual / $18,000 family
Not Applicable	50%	Not Applicable	50%
20%[1]	50%[1]	$25 copay for office visit charge[2] 20% for other services[1]	50%[1]
20%[1]	50%[1]	$25 copay for office visit charge[2] 20% for other services[1]	50%[1]
20%[1]	50%[1]	$25 copay for office visit charge[2] 20% for other services[1]	50%[1]
20%[1]	50%[1]	20%[1]	50%[1]
20%[1]	50%[1]	20%[1]	50%[1]
20%[1]	50%[1]	20%[1]	50%[1]
20%[1]	20%[1]	20%[1]	20%[1]
20%[1]	20%[1]	20%[1]	20%[1]
20%[1]	20%[1]	20%[1]	20%[1]
Not Covered	Not Covered	20%[1] Not Covered on Single Contracts	50%[1] Not Covered on Single Contracts
20%[1]	50%[1]	$25 copay for office visit charge[2] 20% for other services[1]	50%[1]
20%[1]	50%[1]	$25 copay for office visit charge[2] 20% for other services[1]	50%[1]
20%[1]	50%[1]	20%[1]	50%[1]
0% (not subject to deductible)	0% (not subject to deductible)	0% (not subject to deductible)	0% (not subject to deductible)
20%[1]	50%[1]	20%[1]	50%[1]
20%[1] (network transplant facility)	50%[1, 2] (non-network transplant facility)	20%[1] (network transplant facility)	50%[1, 2] (non-network transplant facility)
20%[1]	50%[1, 2]	20%[1]	50%[1, 2]
$7,000,000 maximum per member for Network and Non-network services combined.		$7,000,000 maximum per member for Network and Non-network services combined.	
12 months	12 months	12 months	12 months

PLAN 3

NETWORK YOU PAY	NON-NETWORK YOU PAY
$2,500 individual / $5,000 family $5,000 individual / $10,000 family $10,000 individual / $20,000 family	$5,000 individual / $10,000 family $10,000 individual / $20,000 family $20,000 individual / $40,000 family
$2,500 individual / $5,000 family $5,000 individual / $10,000 family $10,000 individual / $20,000 family	$9,000 individual / $18,000 family $14,000 individual / $28,000 family $24,000 individual / $48,000 family
Not Applicable	50%
0%[1]	50%[1]
0%[1]	50%[1]
0%[1]	50%[1]
0%[1]	50%[1]
0%[1]	50%[1]
0%[1]	50%[1]
0%[1]	0%[1]
0%[1]	0%[1]
0%[1]	0%[1]
Not Covered	Not Covered
0%[1]	50%[1]
0%[1]	50%[1]
0%[1]	50%[1]
0% (not subject to deductible)	0% (not subject to deductible)
0%[1]	50%[1]
0%[1] (network transplant facility)	50%[1, 2] (non-network transplant facility)
0%[1]	50%[1, 2]
$7,000,000 maximum per member for Network and Non-network services combined.	
12 months	12 months

[1] Services subject to calendar-year deductible. Network and Non-network deductibles are separate and do not accumulate towards each other.

[2] Copayment does not apply to deductible or out-of-pocket maximums.

* Services including, but not limited to, transplants, substance abuse and mental health are subject to precertification.

This Blue Access 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 Plan Benefits Guide, the terms of the contract or certificate of coverage will prevail.

PLAN 1 PRESCRIPTION DRUG BENEFITS

NETWORK YOU PAY	NON-NETWORK YOU PAY
Retail (30-day supply): · Generic Formulary - $15 per prescription[2] · Brand-name Formulary - Not covered · Generic Non-formulary - $15 per prescription[2] · Brand-name Non-formulary - Not covered	**Retail (30-day supply):** · Generic Formulary - Not covered · Brand-name Formulary - Not covered · Generic Non-formulary - Not covered · Brand-name Non-formulary - Not covered
Mail Service: · Generic Formulary - Not covered · Brand-name Formulary - Not covered · Generic Non-formulary - Not covered · Brand-name Non-formulary - Not covered	**Mail Service:** · Generic Formulary - Not covered · Brand-name Formulary - Not covered · Generic Non-formulary - Not covered · Brand-name Non-formulary - Not covered

Prescription drug benefits are not subject to deductible.

PLANS 2 AND 3 PRESCRIPTION DRUG BENEFITS

NETWORK YOU PAY	NON-NETWORK YOU PAY
Retail (30-day supply): Tier 1 - $15 per prescription Tier 2 - $30 per prescription Tier 3 - $60 per prescription Tier 4 - 25% per prescription ($2,500 out-of-pocket maximum combined for retail and mail service)	**Retail (30-day supply):** Tier 1 - 50% with a minimum of $60, no maximum Tier 2 - 50% with a minimum of $60, no maximum Tier 3 - 50% with a minimum of $60, no maximum Tier 4 - 50% with a minimum of $60, no maximum
Mail Service (90-day supply): Tier 1 - $30 per prescription Tier 2 - $75 per prescription Tier 3 - $150 per prescription Tier 4 - 25% per prescription ($2,500 out-of-pocket maximum combined for retail and mail service)	**Mail Service - Not Covered**

Prescription drug benefits are not subject to deductible.

Tier 1 - Nearly all Tier 1 drugs are Preferred Generic Prescription Drugs, but Tier 1 may also include some lower cost brand-name drugs with the greatest therapeutic value.
Tier 2 - Preferred Brand-Name and/or Generic Drugs that are lower-cost and provide greater therapeutic value than comparable brand-name drugs.
Tier 3 - Nearly all Tier 3 drugs are Brand-Name drugs that cost more or are less efficient than comparable drugs on lower tiers, but Tier 3 may also include some high-cost generic drugs.
Tier 4 - Generally includes self-injectable drugs. The list of Tier 4 Drugs can be found at anthem.com or by calling the number on the back of your ID card.

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.

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

Who can apply.

You can apply for Blue Access® coverage for yourself or with your family. Family health coverage includes you, your spouse 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 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 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; experimental or investigative treatment; dental and vision, except as spelled out in your contract; 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; 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 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 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.

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 anthem.com.

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