

**Choose the coverage that meets  
your needs. And fits your budget.**

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**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).**



**With healthcare coverage, it's great to have choices.**

**You care about your health. And your family's health. If you didn't, you wouldn't be looking for healthcare coverage. At Anthem Blue Cross and Blue Shield, we know your needs are unique. And important. So we give you choices. And help you decide on a plan that meets your needs without disrupting your budget.**



**Blue Access**  
from Anthem Blue Cross  
and Blue Shield.  
The choices are yours.

## Choose from a wide range of deductibles.

Blue Access lets you choose from a range of deductibles. They start at \$250 and go up to \$10,000. This way, you get to determine your comfort level and premium payments.

If you don't have any major health concerns, you could consider going with a higher deductible and paying lower premiums. Visit the doctor more often? Then maybe you'll want to go with a lower deductible. It could save you money in the long run.

## Choose from three levels of coverage.

Different stages and situations in life require different types of healthcare coverage. This is why Blue Access® gives you a choice of three plans:

- ③ **Blue Access Plan 1** may work well if you're younger and either going to college or self-employed.
- ③ **Blue Access Plan 2** may be a good fit if you're single or married and working. It offers the lowest deductible.
- ③ **Blue Access Plan 3** may be appropriate if you're retired but under the age of 65. It offers the highest deductible options.

Three different levels of coverage to meet your health coverage needs, whatever they may be. So go ahead. Take your pick. It's as easy as one, two, three.

## Choose the right type of prescription drug coverage.

Once again, Blue Access gives you the ability to decide what kind of prescription drug coverage works best for you. If you rarely fill a prescription medication, you may want to go with Plan 1. It has a \$15 co-pay for generics but no brand-name drug coverage or mail-order service. If you use maintenance medications on the other hand, you may want to choose Plan 2 or Plan 3. They each have a \$15 co-pay for generic formulary prescription medications and a \$30 co-pay for brand-name formulary prescription medications as well as mail-order service.

You're in the best position to know what you need. So you make the decision.

## Choose a trusted name in healthcare coverage.

Three options for coverage. A range of deductibles. Prescription drug coverage options. With all this—and a name you can trust backing it up—Blue Access is the smart choice to meet your healthcare coverage needs.

## Stretch your healthcare dollars.

Blue Access Plans 1, 2 and 3 are preferred provider organization (PPO) products. That means, as a member, you get discounts from a network of more than 800,000 physicians and 5,000 hospitals nationwide.<sup>1</sup>

Even when you're seeing a doctor and paying out of your own pocket, our discounts mean you're saving money.

To find your doctor or local hospital, visit [anthem.com](http://anthem.com) and select the "Find a Doctor" button for a complete list of providers within the network.

## Take our coverage along when you travel.

Are you a traveler? When you're on the go, The BlueCard<sup>®</sup> Program assures you of covered services. Nationwide, more than 99 percent of hospitals and 89 percent of physicians contract directly with Blue Cross and Blue Shield Companies.<sup>1</sup> And since BlueCard has providers in more than 200 countries and territories, you'll also be covered internationally. Before you travel, call 1-800-810-BLUE for more information on the BlueCard Program.

## Save on your prescription medications.

Thanks to our 34 million members, our pharmacy benefits manager is able to negotiate significant discounts on prescription medications. When your doctor prescribes medications from our formulary—the technical name for the comprehensive list of prescription medications we cover—you save money. To check out Anthem's formulary, visit [anthem.com](http://anthem.com). Simply select **Visitors**, next select **Anthem Prescription Management**, followed by **Member Online Pharmacy Service**. Next, under **Forms and Documents**, select **More**, and finally, select **Download Anthem National Formulary**.

<sup>1</sup>Blue Cross Blue Shield Association. An Association of Independent Blue Cross Blue Shield Plans. May 2006.

## We have ways to help you stay healthy.

At Anthem, we believe the best healthcare coverage helps people stay healthy.

Which is why we:

- Cover well-child care visits, routine/periodic exams and immunizations once you've met your deductible
- Remind you to have important preventive screenings
- Provide programs and information that help you manage chronic health conditions
- Enable you to add related services such as Dental and Life coverage

## A health manager of your very own.

Also helping to keep you healthy is WebMD's Personal Health Manager. Its online Health Assessment lets you figure out your unique health risks and how to manage them through customized, interactive improvement programs.

LEAP—the Lifetime Exercise Adherence Program created by an Olympic coach—lets you measure your fitness and manage it with the guidance of fitness and health experts.

Then there are WebMD's Condition Centers. They supply useful information about more than 35 health conditions like asthma and diabetes so you can manage them proactively.

## We look after your emotional needs too.

The stresses and strains of daily life can get the best of anybody. That's why Anthem has a comprehensive program of behavioral health services. Confidential management of any behavioral problem is available to you or a covered member of your family. An independent provider will assess your concern or problem promptly.



## You'll have lots of online support.

They say knowledge is power. And part of the power of successfully managing your health comes from having the right information. Which is exactly what we supply through MyAnthem™ at anthem.com. Through MyAnthem you can explore the latest medical technology, compare health care providers, research relevant health topics and learn ways to implement a healthy lifestyle.

**Healthcare Advisor™**— helps you know what to expect when facing an illness, research treatment options, find the best hospital for your needs, prepare for surgery and determine hospitals that have met leading safety standards.

**Treatment Cost Advisor™**— supplies costs for many common medical conditions and healthcare services; estimates for treatments adjusted to your age, gender and location; and comparisons of network and non-network costs.

**PharmaAdvisor®**— quickly identifies different drugs and how they work, their side effects, how they interact with other medications and questions you should ask your doctor about them. Also lets you compare the average wholesale prices of over 11,000 drugs.

**MyHealth@Anthem®**— keep fit with LEAP, find prevention information and track pregnancies and early childhood development, check your health risks and better manage chronic and acute conditions.

**SpecialOffers@Anthem™**— saves you money on health-related products and services like health clubs, home fitness equipment, weight management programs, smoking cessation programs, prescription eyewear, laser vision correction, teeth whitening and veneers, acupuncture and massage therapy.

**Member Services**—you can find a doctor or hospital, order a new ID card, view your benefits, check the status of claims, change your address, see if your medication is on the Anthem formulary and more.

## It's easy to register for MyAnthem.

Just go to anthem.com, select the **Members** tab and appropriate state, then click on the **Enter** button.

When the Member Welcome page comes up, click on the **Register** button and complete the registration form.

These tools are available to all Anthem members and can play a key role in helping you manage your healthcare needs.



### Be prepared for the unexpected.

Pennies a day. That's all it takes to ensure your family has financial protection—even if you're not there to provide for them. When you add the Anthem Blue Preferred® Term Life Plan to your individual medical coverage, you can enjoy the peace of mind that comes from knowing you'll help meet your family's financial obligations. Keep in mind that the death proceeds of a Life policy are almost never taxed.

Blue Preferred Term Life is available with most individual medical plans from Anthem. And it couldn't be easier to get. You won't have to undergo any medical exams or fill out any additional forms. And you'll receive only one bill for your health and life coverage. If you want, you can also get life insurance for all of your individual family members covered on your medical plan. Because there's no such thing as being too prepared.

Term Life Monthly Rates

AGE	\$15,000	\$25,000	\$50,000
Less than 1	\$N/A	\$N/A	\$N/A
1-18	\$1.50	\$2.50	\$N/A
19-29	\$2.85	\$4.75	\$9.50
30-39	\$3.30	\$5.50	\$11.00
40-49	\$7.50	\$12.50	\$25.00
50-59	\$20.85	\$34.75	\$69.50
60-64	\$29.40	\$49.00	\$98.00

## 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](http://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.

## 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.

## 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](http://anthem.com).

This brochure is only a summary of Blue Access' benefits. It isn't part of the contract or certificate of coverage. The contract or certificate of coverage you will receive if you're approved for coverage includes all the details of the plan. In the event of a conflict between the information in this brochure and your contract or certificate of coverage, the terms of your contract or certificate of coverage will prevail. Read your contract or certificate of coverage carefully. Anthem has the right to rescind, cancel, terminate or reform your coverage based on provisions described in the contract or certificate of coverage.

If you aren't satisfied with your Blue Access coverage, you can cancel 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.

# Anthem

MAKING HEALTH CARE COVERAGE EASIER



K E N T U C K Y

**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.**



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PKY-201 (9/07)

Individual

# Blue Access<sup>®</sup>

## 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 1

	NETWORK YOU PAY		NON-NETWORK YOU PAY	
	Individual	Family	Individual	Family
<b>Calendar-year deductible</b>	\$ 500	\$ 1,000	\$ 1,000	\$ 2,000
	\$ 1,000	\$ 2,000	\$ 2,000	\$ 4,000
	\$ 2,500	\$ 5,000	\$ 5,000	\$ 10,000
	\$ 5,000	\$ 10,000	\$ 10,000	\$ 20,000
<b>Out-of-Pocket Maximum</b> <i>(including deductible)</i>	Individual	Family	Individual	Family
	\$ 2,500	\$ 5,000	\$ 5,000	\$ 10,000
	\$ 3,000	\$ 6,000	\$ 6,000	\$ 12,000
	\$ 4,500	\$ 9,000	\$ 9,000	\$ 18,000
	\$ 7,000	\$ 14,000	\$ 14,000	\$ 28,000
<b>Non-network Penalty</b>	Not Applicable		50% <sup>1</sup>	
<b>Physician Office Services</b>	20% <sup>1</sup>		50% <sup>1</sup>	
<b>Preventive Care</b>	20% <sup>1</sup>		50% <sup>1</sup>	
<b>Well Child Care</b>	20% <sup>1</sup>		50% <sup>1</sup>	
<b>Diagnostic Services</b>	20% <sup>1</sup>		50% <sup>1</sup>	
<b>Inpatient Hospital Services</b>	20% <sup>1</sup>		50% <sup>1</sup>	
<b>Outpatient Services</b>	20% <sup>1</sup>		50% <sup>1</sup>	
<b>Emergency Room</b>	20% <sup>1</sup>		20% <sup>1</sup>	
<b>Urgent Care</b>	20% <sup>1</sup>		20% <sup>1</sup>	
<b>Ambulance (includes air)</b>	20% <sup>1</sup>		20% <sup>1</sup>	
<b>Maternity Services</b>	Not Covered		Not Covered	
<b>Outpatient Therapy Services</b>	20% <sup>1</sup>		50% <sup>1</sup>	
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				
<b>Mental Health and Substance Abuse</b>	20% <sup>1</sup>		50% <sup>1</sup>	
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)				
<b>Home Health Care</b> <i>(Maximum visits per benefit period - 60 visits)</i>	20% <sup>1</sup>		50% <sup>1</sup>	

## BLUE ACCESS 1 (CONTINUED)



	NETWORK YOU PAY	NON-NETWORK YOU PAY
<b>Hospice</b>	0% <sup>1</sup> (not subject to deductible)	0% <sup>1</sup> (not subject to deductible)
<b>Durable Medical Equipment</b> <i>(\$4,000 maximum per benefit period)</i>	20% <sup>1</sup>	50% <sup>1</sup>
<b>Prosthetic Devices</b> <i>(\$4,000 maximum per benefit period)</i>		
<b>Human Organ and Tissue Transplant Services</b> <i>(for kidney and cornea transplants, services covered same as any other illness under Medical)</i>	20% <sup>1</sup> (network transplant facility)	50% <sup>1,2</sup> (non-network transplant facility)
<b>Transportation, Lodging and Meals</b>	20% <sup>1</sup>	50% <sup>1,2</sup>
<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

### PRESCRIPTION DRUG BENEFITS

#### NETWORK YOU PAY

##### Retail (30-day supply):

- Generic Formulary - \$15 per prescription<sup>2</sup>
- Brand-name Formulary - Not covered
- Generic Non-formulary - \$15 per prescription<sup>2</sup>
- Brand-name Non-formulary - Not covered

##### Mail Service (90-day supply):

- Generic Formulary - Not covered
- Brand-name Formulary - Not covered
- Generic Non-formulary - Not covered
- Brand-name Non-formulary - Not covered

#### NON-NETWORK YOU PAY

##### 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 (90-day supply):

- 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.

Mail order and prescription drug benefits administered by WellPoint NextRx.

<sup>1</sup> Services subject to calendar-year deductible. Network and Non-network deductibles are separate and do not accumulate towards each other.

<sup>2</sup> 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.

	NETWORK YOU PAY		NON-NETWORK YOU PAY	
	Individual	Family	Individual	Family
Calendar-year deductible	\$ 250	\$ 500	\$ 500	\$ 1,000
	\$ 500	\$ 1,000	\$ 1,000	\$ 2,000
	\$ 1,000	\$ 2,000	\$ 2,000	\$ 4,000
	\$ 2,500	\$ 5,000	\$ 5,000	\$ 10,000
Out-of-Pocket Maximum <i>(including deductible)</i>	\$ 2,250	\$ 4,500	\$ 4,500	\$ 9,000
	\$ 2,500	\$ 5,000	\$ 5,000	\$ 10,000
	\$ 3,000	\$ 6,000	\$ 6,000	\$ 12,000
	\$ 4,500	\$ 9,000	\$ 9,000	\$ 18,000
Non-network Penalty	Not Applicable		50% <sup>1</sup>	
Physician Office Services	\$25 copay for office visit charge <sup>2</sup> 20% for other services <sup>1</sup>		50% <sup>1</sup>	
Preventive Care	\$25 copay for office visit charge <sup>2</sup> 20% for other services <sup>1</sup>		50% <sup>1</sup>	
Well Child Care	\$25 copay for office visit charge <sup>2</sup> 20% for other services <sup>1</sup>		50% <sup>1</sup>	
Diagnostic Services	20% <sup>1</sup>		50% <sup>1</sup>	
Inpatient Hospital Services	20% <sup>1</sup>		50% <sup>1</sup>	
Outpatient Services	20% <sup>1</sup>		50% <sup>1</sup>	
Emergency Room	20% <sup>1</sup>		20% <sup>1</sup>	
Urgent Care	20% <sup>1</sup>		20% <sup>1</sup>	
Ambulance (includes air)	20% <sup>1</sup>		20% <sup>1</sup>	
Maternity Services	20% <sup>1</sup> Not Covered on Single Contracts		20% <sup>1</sup> Not Covered on Single Contracts	
Outpatient Therapy Services	\$25 copay for office visit charge <sup>2</sup> 20% for other services <sup>1</sup>		50% <sup>1</sup>	
Maximum visits per benefit period for Network and Non-network combined: <ul style="list-style-type: none"> <li>Physical Therapy and Manipulation Therapy - 20 visits maximum</li> <li>Speech Therapy - 20 visits maximum</li> <li>Occupational Therapy - 20 visits maximum</li> </ul>				
Mental Health and Substance Abuse	\$25 copay for office visit charge <sup>2</sup> 20% for other services <sup>1</sup>		50% <sup>1</sup>	
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 <i>(Max. visits per benefit period - 60 visits)</i>	20% <sup>1</sup>		50% <sup>1</sup>	

	NETWORK YOU PAY	NON-NETWORK YOU PAY
Hospice	0% <sup>1</sup> (not subject to deductible)	0% <sup>1</sup> (not subject to deductible)
Durable Medical Equipment <i>(\$4,000 maximum per benefit period)</i>	20% <sup>1</sup>	50% <sup>1</sup>
Prosthetic Devices <i>(\$4,000 maximum per benefit period)</i>		
Human Organ and Tissue Transplant Services <i>(for kidney and cornea transplants, services covered same as any other illness under Medical)</i>	20% <sup>1</sup> (network transplant facility)	50% <sup>1,2</sup> (non-network transplant facility)
Transportation, Lodging and Meals	20% <sup>1</sup>	50% <sup>1,2</sup>
Plan Lifetime Maximum	\$7,000,000 maximum per member for Network and Non-network services combined.	
Preexisting Waiting Period	12 months	12 months

**PRESCRIPTION DRUG BENEFITS**

NETWORK YOU PAY	NON-NETWORK YOU PAY
<b>Retail (30-day supply):</b> <ul style="list-style-type: none"> <li>Tier 1 - \$15 per prescription</li> <li>Tier 2 - \$30 per prescription</li> <li>Tier 3 - \$60 per prescription</li> <li>Tier 4 - 25% per prescription (\$2,500 out-of-pocket maximum combined for retail and mail service)</li> </ul>	<b>Retail (30-day supply):</b> <ul style="list-style-type: none"> <li>Tier 1 - 50% with a min. of \$60, no max.</li> <li>Tier 2 - 50% with a min. of \$60, no max.</li> <li>Tier 3 - 50% with a min. of \$60, no max.</li> <li>Tier 4 - 50% with a min. of \$60, no max.</li> </ul>
<b>Mail Service (90-day supply):</b> <ul style="list-style-type: none"> <li>Tier 1 - \$30 per prescription</li> <li>Tier 2 - \$75 per prescription</li> <li>Tier 3 - \$150 per prescription</li> <li>Tier 4 - 25% per prescription (\$2,500 out-of-pocket maximum combined for retail and mail service)</li> </ul>	<b>Mail Service (90-day supply):</b> 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 [www.anthem.com](http://www.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.

<sup>1</sup> Services subject to calendar-year deductible. Network and Non-network deductibles are separate and do not accumulate towards each other.

<sup>2</sup> 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.

## BLUE ACCESS 3

	NETWORK YOU PAY		NON-NETWORK YOU PAY	
	Individual	Family	Individual	Family
Calendar-year deductible	\$ 2,500	\$ 5,000	\$ 5,000	\$ 10,000
	\$ 5,000	\$ 10,000	\$ 10,000	\$ 20,000
	\$ 10,000	\$ 20,000	\$ 20,000	\$ 40,000
Out-of-Pocket Maximum (including deductible)	\$ 2,500	\$ 5,000	\$ 9,000	\$ 18,000
	\$ 5,000	\$ 10,000	\$ 14,000	\$ 28,000
	\$ 10,000	\$ 20,000	\$ 24,000	\$ 48,000
Non-network Penalty	Not Applicable		50% <sup>1</sup>	
Physician Office Services	0% <sup>1</sup>		50% <sup>1</sup>	
Preventive Care	0% <sup>1</sup>		50% <sup>1</sup>	
Well Child Care	0% <sup>1</sup>		50% <sup>1</sup>	
Diagnostic Services	0% <sup>1</sup>		50% <sup>1</sup>	
Inpatient Hospital Services	0% <sup>1</sup>		50% <sup>1</sup>	
Outpatient Services	0% <sup>1</sup>		50% <sup>1</sup>	
Emergency Room	0% <sup>1</sup>		0% <sup>1</sup>	
Urgent Care	0% <sup>1</sup>		0% <sup>1</sup>	
Ambulance (includes air)	0% <sup>1</sup>		0% <sup>1</sup>	
Maternity Services	Not Covered		Not Covered	
Outpatient Therapy Services	0% <sup>1</sup>		50% <sup>1</sup>	
Maximum visits per benefit period for Network and Non-network combined: <ul style="list-style-type: none"> <li>Physical Therapy and Manipulation Therapy - 20 visits maximum</li> <li>Speech Therapy - 20 visits maximum</li> <li>Occupational Therapy - 20 visits maximum</li> </ul>				
Mental Health and Substance Abuse	0% <sup>1</sup>		50% <sup>1</sup>	
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)	0% <sup>1</sup>		50% <sup>1</sup>	

## BLUE ACCESS 3 (CONTINUED)



	NETWORK YOU PAY	NON-NETWORK YOU PAY
Hospice	0% <sup>1</sup> (not subject to deductible)	0% <sup>1</sup> (not subject to deductible)
Durable Medical Equipment ( <i>\$4,000 maximum per benefit period</i> )	0% <sup>1</sup>	50% <sup>1</sup>
Prosthetic Devices ( <i>\$4,000 maximum per benefit period</i> )		
Human Organ and Tissue Transplant Services ( <i>for kidney and cornea transplants, services covered same as any other illness under Medical</i> )	0% <sup>1</sup> (network transplant facility)	50% <sup>1,2</sup> (non-network transplant facility)
Transportation, Lodging and Meals	0% <sup>1</sup>	50% <sup>1,2</sup>
Plan Lifetime Maximum	\$7,000,000 maximum per member for Network and Non-network services combined.	
Preexisting Waiting Period	12 months	12 months

### PRESCRIPTION DRUG BENEFITS

#### 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*)

##### 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*)

#### NON-NETWORK YOU PAY

##### Retail (30-day supply):

- Tier 1 - 50% with a min. of \$60, no max.
- Tier 2 - 50% with a min. of \$60, no max.
- Tier 3 - 50% with a min. of \$60, no max.
- Tier 4 - 50% with a min. of \$60, no max.

##### Mail Service (90-day supply):

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 [www.anthem.com](http://www.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.

<sup>1</sup> Services subject to calendar-year deductible. Network and Non-network deductibles are separate and do not accumulate towards each other.

<sup>2</sup> 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.

## 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 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 [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.

## 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).