

K E N T U C K Y

This KY Blue Access Standard 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 KY Blue Access Standard Guide, the terms of the contract or certificate of coverage will prevail.



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Blue Access[®] Standard

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.

BLUE ACCESS STANDARD

	NETWORK YOU PAY		NON-NETWORK YOU PAY	
	Individual	Family	Individual	Family
Calendar-year deductible	\$ 400	\$ 800	\$ 700	\$ 1,400
Out-of-Pocket Maximum (including deductible)	\$ 1,500	\$ 3,000	\$ 2,500	\$ 5,000
Physician Office Services Provider office visits (includes well child, well adult, immunizations, office diagnostic testing, allergy testing, diabetes education and therapy, and other office visits) · Preventive care and well child care · Allergy serum and injections · Radiation · Dialysis · Chemotherapy	\$10 copayment per visit (not subject to deductible) (No copayment applies when allergy injection/serum is the only charge)	40% ¹ Well child care, well adult, immunizations and early detection services are not covered out-of-network. (No copayment applies when allergy injection/serum is the only charge)		
Inpatient Hospital Services · Provider services, authorized inpatient care in semi-private room, miscellaneous hospital services, intensive/cardiac/neonatal care, ancillary services, surgical services, pre-admission testing, use of operating, recovery and delivery rooms, ancillary services, surgical services, pre-admission testing, blood and blood plasma, and routine nursery care for newborns · Transplants – limited to kidney, cornea, bone marrow, heart, liver, lung, heart/lung, small bowel and pancreas* · Maternity care (including dependents)	15% of eligible expense, not subject to deductible	35% ¹		
Outpatient Services · Diagnostic tests · Ambulatory/hospital outpatient surgery	20% ¹	40% ¹		
Emergency Room · Hospital emergency room · Ambulance (ground only) (If not an emergency medical condition, all services will be denied.)	20% ¹ (emergency room coinsurance waived if admitted)	20% ¹		
Urgent Care	\$25 copayment	\$25 copayment		
Ambulance (includes air)	30% ¹	30% ¹		

Cost Containment

Services or supplies eligible for coverage must meet our criteria for medical necessity on the date the service is rendered. Covered persons must follow cost containment guidelines or benefits may be reduced as indicated in your Health Benefits contract. (Refer to your contract for a procedures list.)

Components of the program include:

- Pre-admission certification and admission review
- Ambulatory surgery
- Continued stay review
- Outpatient precertification

Exceptions to non-network utilization benefit reduction:

- Emergency services
- Covered services for eligible dependent children residing out of the service area due to such children attending an out-of-area educational institution, or residing with a member's former spouse.

BLUE ACCESS STANDARD (CONTINUED)



	NETWORK YOU PAY	NON-NETWORK YOU PAY
Mental Health and Substance Abuse*	20% ¹ Coinsurance/copayment applicable to service provided	40% ¹ Benefits applicable to service provided
Mental Health · Inpatient services (maximum 21 days per calendar year) one admission per six months. Intensive outpatient day treatment can be substituted for inpatient days on a two-for-one basis. · Outpatient services (20 visits per calendar year) · Autism - therapeutic, respite and rehabilitative care (\$500 per month for children ages 2 through 21)		
Substance Abuse · Inpatient services (maximum 21 days per calendar year) one admission per six months. Intensive outpatient day treatment can be substituted for inpatient days on a two-for-one basis. · Outpatient services (20 visits per calendar year)		
Other Services · Prescription drugs (including contraceptives) – one-month supply · Skilled nursing facility – 30 days per calendar year · Physical, Occupational, Outpatient Cardiac Rehabilitation Therapy · Physician/Osteopathic/ Chiropractic Manipulation Treatment · Speech Therapy · Durable medical equipment, prosthetic appliances, hearing aids and orthotic devices · Home health care – 100 maximum visits per calendar year · Hospice services	20% ¹ 20% ¹ 20% - 30 visits per plan year 20% - 20 visits per plan year 20% - 30 visits per plan year 0% ¹ 0% ¹ (not subject to deductible) 0% ¹ (not subject to deductible)	40% ¹ 40% ¹ 40% - 30 visits per plan year 40% - 20 visits per plan year 40% - 30 visits per plan year 20% ¹ 0% ¹ (not subject to deductible) 0% ¹ (not subject to deductible)
OPTIONAL: Mental Health Rider	Removes day limits	Removes day limits
OPTIONAL: \$15 Prescription Drug Rider	\$15 copayment per prescription	Not covered. Must use network pharmacy.
Plan Lifetime Maximum	Unlimited	Unlimited

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.

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 Standard 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 Standard 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, 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.