Individual Blue Access℠ Value Plan Benefit Summary

Covered Benefits	Network - You Pay	Non-Network - You Pay
Calendar-year Deductible *(The network and non-network deductibles accumulate toward each other.)* ***NOTE: The deductible applies to all covered services except Office Visits, Hospice, certain Outpatient Diagnostic Services and Prescription Drugs.***	$2,000 Single / $4,000 Family $3,000 Single / $6,000 Family $5,000 Single / $10,000 Family $10,000 Single / $20,000 Family	$4,000 Single / $8,000 Family $6,000 Single / $12,000 Family $10,000 Single / $20,000 Family $20,000 Single / $40,000 Family
Out-of-pocket Limit *(includes deductible)* ***NOTE: The Out-of-pocket Limit does not include flat dollar copayments, prescription drug copayments and deductibles or coinsurance for non-network Human Organ and TissueTransplant.***	$5,000 Single / $10,000 Family $6,000 Single / $12,000 Family $8,000 Single / $16,000 Family $13,000 Single / $26,000 Family	$10,000 Single / $20,000 Family $12,000 Single / $24,000 Family $16,000 Single / $32,000 Family $26,000 Single / $52,000 Family
Lifetime Maximum	$5 million maximum per member for network and non-network services combined	
Prescription Drugs ***NOTE: Anthem pays $500 maximum per person, per calendar year, for both retail and mail service combined.***		
Generic Formulary Drugs	$10 per prescription.[1] (30-day supply not subject to deductible)	Not Covered
Brand-name Formulary Drugs	$200 deductible per calendar year,[1] then $25 per prescription for 30-day supply[1]	Not Covered
Generic Non-Formulary Drugs	$10 per prescription.[1] (30-day supply, not subject to deductible)	Not Covered
Brand-name Non-Formulary Drugs	Not Covered	Not Covered
Mail Service Generic Formulary Drugs	$20 per prescription[1] (90-day supply, not subject to deductible)	Not Covered
Mail Service Brand-name Formulary Drugs	$200 deductible per calendar year[1], then $50 per prescription for 90-day supply[1]	Not Covered
Mail Service Brand-name Non-Formulary Drugs	Not Covered	Not Covered
Physicians Office Visits **All medical office visits including office visits associated with a routine pap smear, annual mammogram, colorectal cancer screening or PSA screening.**	Visits 1 and 2, member pays $30 copayment.[1, 2] 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+ - Not Covered	Visits 1 and 2, member pays 40% coinsurance.[2] The deductible does not apply to these office visits. Other covered office services subject to deductible and 40% coinsurance. Visits 3+ - Not Covered
Inpatient Hospital Services	30% coinsurance after deductible	40% coinsurance after deductible
Outpatient Services	30% coinsurance after deductible	40% coinsurance after deductible
Diagnostic Services ***NOTE: $300 maximum per member, per calendar year, network and non-network combined.*** (Includes lab work and X-rays and Outpatient Diagnostic Services. Preventive services excluded from the $300 limit)	30% coinsurance (not subject to deductible)	40% coinsurance (not subject to deductible)
Adult Preventive Care ***NOTE: Lab/X-Ray for routine Pap smear, annual mammogram, colorectal cancer screening or PSA screening ONLY. Other preventive care services are not covered.***	30% coinsurance after deductible	40% coinsurance after deductible
Well Child Care and Immunizations; other routine services not outlined above, such as flu shots or routine physical exams/tests.	Not Covered	Not Covered

Individual Blue Access℠ Value Plan Benefit Summary *(continued)*

Covered Benefits	Network - You Pay	Non-Network - You Pay
Emergency Room	30% coinsurance after deductible (additional $60 copayment if not admitted[1])	30% coinsurance after deductible (additional $60 copayment if not admitted[1])
Urgent Care	30% coinsurance after deductible	30% coinsurance after deductible
Ambulance Our payment is limited to a maximum per Benefit Period of $2,500. You are responsible for any amounts in excess of our payment.	30% coinsurance after deductible	30% coinsurance after deductible
Mental Health / Substance Abuse Inpatient	30% coinsurance after deductible	40% coinsurance after deductible
	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
Mental Health / Substance Abuse Outpatient	30% coinsurance after deductible	40% coinsurance after deductible
	Outpatient Mental Health Services - Limited to 10 days 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
	Inpatient and Outpatient Substance Abuse Rehabilitation Programs are limited to 2 per lifetime. (Includes both Network and Non-Network)	
Mental Health / Substance Abuse Physician Office Visit & Examination (Limit 2 visits per calendar year, combined with physician office visit limit for medical services)	Visits 1 and 2, member pays $30 copayment, no deductible. Visits 3+ - NOT COVERED	Visits 1 and 2, member pays 40% 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
Home Health Care (Maximum of 60 visits per calendar year)	30% coinsurance after deductible	40% coinsurance after deductible
Hospice	0% (not subject to deductible)	0% (not subject to deductible)
Skilled Nursing (Limit of 100 days per Calendar year)	30% coinsurance after deductible	40% coinsurance after deductible
Human Organ & Tissue Transplant	30% coinsurance after deductible	40% coinsurance after deductible (Coinsurance does not apply to out-of-pocket maximum)
Durable Medical Equipment	Not Covered	Not Covered
Outpatient Therapy Services		
Physical Therapy	Not Covered	Not Covered
Speech Therapy	Not Covered	Not Covered
Occupational Therapy	Not Covered	Not Covered
Spinal Manipulation	Not Covered	Not Covered
Optional Benefits	**Network - You Pay**	**Non-Network - You Pay**
Extended Mental Health Rider Mental health treated same as any other medical condition (Limit 2 visits per calendar year, combined with physician office visit limit for medical services)	Office Visit - Visits 1 and 2, member pays $30 copayment, no deductible. Visits 3+ - Not Covered. Other Services - 30% coinsurance after deductible	Office Visit - Visits 1 and 2, member pays 40% 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% coinsurance after deductible

FOOTNOTES:
1 Copayment does not apply to deductible or out-of-pocket maximums.
2 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.

Exclusions and limitations apply to the Plan. Please see contract or certificate for details.

For Your Information

Anthem's Individual Blue Access Value Plans do not provide benefits for services, supplies or charges related to:

- Private duty nursing
- Maternity services
- Experimental or investigative treatment
- Charges in excess of the maximum allowable amount
- Care provided by a member of your immediate family
- Treatment that is primarily intended to improve your appearance
- Weight loss or treatment of obesity
- Hearing aids
- Eyeglasses or contact lenses
- Radial keratotomy or keratomileusis or excimer laser photo refractive keratectomy
- Artificial insemination, fertilization, infertility drugs, sterilization reversal
- Sex transformation surgery
- Artificial or mechanical hearts
- Custodial care
- Contraceptives
- Services which we determine are not medically necessary

This is a partial listing of exclusions contained in the plan. Consult your Contract and Schedule of Benefits for a complete list of benefits, exclusions and maximum payment levels.

The contract associated with the Blue Access Value Plan is a basic health benefit plan, as defined by Kentucky law, that provides limited coverage to the persons issued coverage under such contract. The contract excludes chiropractic services, food for metabolic disorders and PKU disorders, TMJ and craniomandibular joint disorder services, cochlear implants, autism and hearing aids, which are state-mandated benefits. Please note that the benefits for diabetes and hospice, as required by Kentucky law, are not excluded from the Blue Access Value Plan contract and the contract also includes all federally mandated benefits.