



O H I O

Individual  
Blue Access Value

## PLAN BENEFITS GUIDE

### Calendar-year deductible

### Out-of-Pocket Maximum (including deductible)

### Physician Office Services

All medical office visits including office visits associated with a routine pap smear, annual mammogram, colorectal cancer screening or PSA screening.

### 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.

### Well Child Care

(From birth to 12 months; \$500 maximum, from age 1 through 8, \$150 maximum per year; limits are combined for network and non-network services)

### Diagnostic Services

*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).

### Inpatient Hospital Services

### Outpatient Services

### Emergency Room

### Urgent Care

### Ambulance (includes air)

*NOTE:* \$2,500 maximum allowable amount per person per benefit period. The \$2,500 maximum allowable amount is subject to deductible and coinsurance.

### Maternity Services

### Outpatient Therapy Services

### Mental Health/Substance Abuse Inpatient - 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 - 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.

### Mental Health/Substance Abuse Physician Office Visit & Examination

(Limit 2 visits per calendar year, combined with physician office visit limit for medical services)

### OPTIONAL - Extended Mental Health Rider

*NOTE:* Mental health treated same as any other condition (Limit 2 visits per calendar year, combined with physician office visit limit for medical services)

## VALUE PLAN

NETWORK YOU PAY	NON-NETWORK YOU PAY
\$2,000 individual / \$4,000 family \$3,000 individual / \$6,000 family \$5,000 individual / \$10,000 family \$10,000 individual / \$20,000 family	\$4,000 individual / \$8,000 family \$6,000 individual / \$12,000 family \$10,000 individual / \$20,000 family \$20,000 individual / \$40,000 family
\$5,000 individual / \$10,000 family \$6,000 individual / \$12,000 family \$8,000 individual / \$16,000 family \$13,000 individual / \$26,000 family	\$10,000 individual / \$20,000 family \$12,000 individual / \$24,000 family \$16,000 individual / \$32,000 family \$26,000 individual / \$52,000 family
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 (copayment applies to office charge only). Other covered office services subject to deductible and 30% coinsurance. Visits 3+ are not covered.
30% coinsurance after deductible	40% coinsurance after deductible
30% coinsurance after deductible for state mandate only	40% coinsurance after deductible for state mandate only
30% (not subject to deductible)	40% (not subject to deductible)
30% <sup>1</sup>	40% <sup>1</sup>
30% <sup>1</sup>	40% <sup>1</sup>
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> )
30% <sup>1</sup>	30% <sup>1</sup>
30% <sup>1</sup>	30% <sup>1</sup>
Not Covered	Not Covered
Not Covered	Not Covered
30% <sup>1</sup>	40% <sup>1</sup>
30% <sup>1</sup>	40% <sup>1</sup>
Visits 1 and 2, member pays \$30 <sup>2,3</sup> copayment, no deductible. Visits 3+ not covered	Visits 1 and 2, member pays \$30 <sup>3</sup> copayment, no deductible. Visits 3+ not covered
Office Visit - Visits 1 and 2, member pays \$30 <sup>2,3</sup> copayment, no deductible. Visits 3+ - Not Covered. Other Services - 30% coinsurance after deductible	Office Visit - Visits 1 and 2, member pays 40% <sup>3</sup> , 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>

<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.

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.

VALUE PLAN (CONT.)		
	NETWORK YOU PAY	NON-NETWORK YOU PAY
Home Health Care (Maximum visits per benefit period - 60 visits)	30% <sup>1</sup>	40% <sup>1</sup>
Hospice	0% (not subject to deductible)	0% (not subject to deductible)
Medical Supplies, Durable Medical Equipment	Not Covered	Not Covered
Human Organ and Tissue Transplant Services	30% <sup>1</sup>	40% <sup>1</sup> (coinsurance does not apply to out-of-pocket maximum)
Plan Lifetime Maximum	\$5,000,000 maximum per member for network and non-network services combined	
Preexisting Waiting Period	12 months	12 months

Exclusions and limitations apply to the plan. Please see contract or certificate of coverage for details.

## VALUE PLAN 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 - \$25 per prescription<sup>2</sup> (\$200 deductible per calendar year)</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 - 50% coinsurance</li> <li>Brand-name Formulary - Separate Non-network \$200 deductible per person, per calendar year, then 50% coinsurance per prescription</li> <li>Generic Non-formulary - 50% coinsurance</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 - \$50 per prescription<sup>2</sup> (\$200 deductible per calendar year)</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.

Prescription drug benefits are not subject to deductible.



