



M I S S O U R I

Blue Access Value
Blue Access Choice Value

PLAN BENEFITS GUIDE

Calendar-year deductible

Out-of-Pocket Maximum (including deductible)

Physician Office Services

Preventive Care

NOTE: Lab/X-Ray for routine pap smear, annual mammogram, colorectal cancer screening, PSA screening, pelvic exam, hearing screenings (including newborn), bone density tests, routine costs associated with clinical trials, lead poisoning testing only. Other preventive care services are not covered.

Well Child Care

NOTE: Childhood immunizations through age 5 only. Other well child care services are not covered.

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)

Maternity Services

Outpatient Therapy Services

Mental Health

- Inpatient
- Outpatient

Substance Abuse

- Inpatient
- Outpatient

Home Health Care (Maximum visits per benefit period - 40 visits)

Hospice

Durable Medical Equipment

Human Organ and Tissue Transplant Services

Plan Lifetime Maximum

Preexisting Waiting Period

VALUE PLAN

NETWORK YOU PAY	NON-NETWORK YOU PAY
\$2,000 individual / \$6,000 family \$3,000 individual / \$9,000 family \$5,000 individual / \$15,000 family \$10,000 individual / \$30,000 family	\$4,000 individual / \$12,000 family \$6,000 individual / \$18,000 family \$10,000 individual / \$30,000 family \$20,000 individual / \$60,000 family
\$6,000 individual / \$12,000 family \$7,000 individual / \$14,000 family \$9,000 individual / \$18,000 family \$14,000 individual / \$30,000 family	\$12,000 individual / \$24,000 family \$14,000 individual / \$28,000 family \$18,000 individual / \$36,000 family \$28,000 individual / \$60,000 family
\$30 ¹ for office visit charge (first 2 visits only). 30% ¹ for other services. Visits 3+ are not covered.	50% ^{1,4} for first 2 office visits. Visits 3+ are not covered.
30% ¹	50% ¹
0% (not subject to deductible)	0% (not subject to deductible)
30% (not subject to deductible)	50% (not subject to deductible)
30% ¹	50% ¹
30% ¹	50% ¹
30% ¹	30% ¹
30% ¹	50% ¹
30% ¹	30% ¹
Not Covered	Not Covered
Physical Therapy - Not Covered Occupational Therapy - Not Covered Speech Therapy - 30% ¹ Spinal Manipulation - Not Covered	Physical Therapy - Not Covered Occupational Therapy - Not Covered Speech Therapy - 50% ¹ Spinal Manipulation - Not Covered
Not Covered Not Covered	Not Covered Not Covered
Not Covered Not Covered	Not Covered Not Covered
30% ¹	50% ¹
30% ¹	50% ¹
Not Covered	Not Covered
30% ¹	50% ¹ (Non-network transplant facility), deductible and coinsurance does not apply to out-of-pocket maximums
Unlimited	Unlimited
12 months	12 months

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

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.

³ If brand name drug is purchased when a generic equivalent is available, you are responsible for the difference between the allowed charges for the generic and the brand name drug, in addition to the generic copay.

⁴ Subsequent office visits are not covered for Physician office visits, but other services may be covered.

*** Blue Access plans are available to residents in 85 Missouri counties.**

*** Blue Access Choice plans are available to residents of St. Louis City and St. Louis, St. Charles, Warren, Jefferson, St. Francois and Franklin counties.**

PRESCRIPTION DRUG BENEFITS

You can choose from three prescription benefit options as shown below.

PRESCRIPTION DRUG BENEFIT OPTION: \$500 DEDUCTIBLE \$15/\$30/\$60/25%

NETWORK YOU PAY	NON-NETWORK YOU PAY
<p>Retail (30-day supply):</p> <ul style="list-style-type: none"> • Tier 1 - \$15 per prescription • Tier 2 - \$30 per prescription (subject to a \$500 drug deductible) • Tier 3 - \$60 per prescription (subject to a \$500 drug deductible) • Tier 4 - 25% per prescription (\$2,500 out-of-pocket maximum) <p>Mail Service (90-day supply):</p> <ul style="list-style-type: none"> • Tier 1 - \$30 per prescription • Tier 2 - \$75 per prescription (subject to a \$500 drug deductible) • Tier 3 - \$150 per prescription (subject to a \$500 drug deductible) • Tier 4 - 25% per prescription (\$2,500 out-of-pocket maximum) 	<p>Retail (30-day supply):</p> <ul style="list-style-type: none"> • Tier 1 - 50% with a minimum of \$60 • Tier 2 - 50% with a minimum of \$60 (subject to a \$500 drug deductible) • Tier 3 - 50% with a minimum of \$60 (subject to a \$500 drug deductible) • Tier 4 - 50% with a minimum of \$60 (no maximum) <p>Mail Service - Not covered</p>

PRESCRIPTION DRUG BENEFIT OPTION: \$15 GENERIC ONLY

NETWORK YOU PAY	NON-NETWORK YOU PAY
<p>Retail (30-day supply):</p> <ul style="list-style-type: none"> • Generic Prescription Drugs - \$15 per prescription, \$500 maximum per person per calendar year. Brand-name prescription drugs are not covered. However, you can get discounts on brand-name drugs with your Anthem Blue Cross and Blue Shield ID card. <p>Mail Service (90-day supply):</p> <ul style="list-style-type: none"> • Generic Prescription Drugs - \$30 per prescription, \$500 maximum per person per calendar year. Brand-name prescription drugs are not covered. 	<p>Retail (30-day supply):</p> <ul style="list-style-type: none"> • Generic Prescription Drugs - 50% with a minimum of \$15, \$500 maximum per person per calendar year. Brand-name prescription drugs are not covered. Prescription discounts are not applicable if the provider is non-network. <p>Mail Service - Not covered</p>

PRESCRIPTION DRUG BENEFIT OPTION: DISCOUNT ONLY

NETWORK YOU PAY	NON-NETWORK YOU PAY
<p>Prescription drugs are not covered. However, you can get discounts on prescription drugs with your Anthem Blue Cross and Blue Shield ID card.</p>	<p>Prescription drugs are not covered. Prescription discounts are not applicable if the provider is non-network.</p>

- 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 or by calling the number on the back of your ID card.

NOTE: If a brand-name drug is purchased when a generic equivalent is available, you are responsible for the difference between the allowed charges for the generic and the brand-name drug, in addition to the generic copay.

Prescription drug benefits administered by WellPoint NextRx, an affiliate of Anthem Blue Cross and Blue Shield. Mail order prescription drug benefits administered by Precision Rx.



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