MISSOURI

Individual

Blue Access 80, 90, 100

Blue Access Choice 80, 90, 100

PLAN BENEFITS GUIDE

Calendar-year deductible

Out-of-Pocket Maximum (including deductible)

Physician Office Services

Preventive Care

Well Child Care
NOTE: routine immunizations are covered at 100% through age 5 (Network and Non-Network)

Diagnostic Services

Inpatient Hospital Services

Outpatient Services

Emergency Room

Urgent Care

Ambulance (includes air)

Maternity Services

Optional Maternity Rider
(Subject to a 12 month waiting period. Dependent daughters are not covered.)

Outpatient Therapy Services
Maximum visits per benefit period for Network and Non-network combined:
- Physical Therapy and Spinal Manipulation - 20 visits maximum
- Speech Therapy - no maximum
- Occupational Therapy - 20 visits maximum

Mental Health
- Inpatient (Maximum per benefit period - 90 days)
- Outpatient

Substance Abuse (Inpatient and outpatient substance abuse rehabilitation programs are limited to ten episodes per lifetime.)
- Inpatient (Maximum per benefit period - 21 days, plus 6 days for detoxification)
- Outpatient (Maximum per benefit period for physician home visits and office services - 30 visits. Maximum per benefit period for facility based outpatient treatment program - 30 days)

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

Hospice

Durable Medical Equipment, Orthotics (Maximum per benefit period - $4,000)

Human Organ and Tissue Transplant Services

Plan Lifetime Maximum

Preexisting Waiting Period

PLAN 80

PLAN 90

Plan 80 Network You Pay	Plan 80 Non-Network You Pay	Plan 90 Network You Pay	Plan 90 Non-Network You Pay
\$500 individual / \$1,500 family \$1,000 individual / \$3,000 family \$2,500 individual / \$7,500 family \$5,000 individual / \$15,000 family \$7,500 individual / \$22,500 family	\$1,000 individual / \$3,000 family \$2,000 individual / \$6,000 family \$5,000 individual / \$15,000 family \$10,000 individual / \$30,000 family \$15,000 individual / \$45,000 family	\$250 individual / \$750 family \$500 individual / \$1,500 family \$1,000 individual / \$3,000 family \$2,500 individual / \$7,500 family	\$500 individual / \$1,500 family \$1,000 individual / \$3,000 family \$2,000 individual / \$6,000 family \$5,000 individual / \$15,000 family
\$3,500 individual / \$7,000 family \$4,000 individual / \$8,000 family \$5,500 individual / \$11,000 family \$8,000 individual / \$16,000 family \$10,500 individual / \$22,500 family	\$7,000 individual / \$14,000 family \$8,000 individual / \$16,000 family \$11,000 individual / \$22,000 family \$16,000 individual / \$32,000 family \$21,000 individual / \$45,000 family	\$3,250 individual / \$6,500 family \$3,500 individual / \$7,000 family \$4,000 individual / \$8,000 family \$5,500 individual / \$11,000 family	\$6,500 individual / \$13,000 family \$7,000 individual / \$14,000 family \$8,000 individual / \$16,000 family \$11,000 individual / \$22,000 family
\$25 copay for office visit charge[2] 20% for other services[1]	40%[1]	\$25 copay for office visit charge[2] 10% for other services[1]	40%[1]
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20%[1]	20%[1]	10%[1]	10%[1]
Not Covered	Not Covered	Not Covered	Not Covered
20%[1]	40%[1]	10%[1]	40%[1]
\$25 copay for office visit charge[2] 20% for other services[1]	40%[1]	\$25 copay for office visit charge[2] 10% for other services[1]	40%[1]
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20%[1]	40%[1]	10%[1]	40%[1]
20%[1]	40%[1]	10%[1]	40%[1]
20%[1]	40%[1] (Non-network transplant facility), deductible and coinsurance does not apply to out-of-pocket maximums	10%[1]	40%[1] (Non-network transplant facility), deductible and coinsurance does not apply to out-of-pocket maximums
Unlimited	Unlimited	Unlimited	Unlimited
12 months	12 months	12 months	12 months

Exclusions and limitations apply to the plan. Please see contract or certificat

PLAN 100

NETWORK YOU PAY	NON-NETWORK YOU PAY
$500 individual / $1,500 family $1,000 individual / $3,000 family $2,500 individual / $7,500 family $5,000 individual / $15,000 family $7,500 individual / $22,500 family $10,000 individual / $30,000 family	$1,000 individual / $3,000 family $2,000 individual / $6,000 family $5,000 individual / $15,000 family $10,000 individual / $30,000 family $15,000 individual / $45,000 family $20,000 individual / $60,000 family
$500 individual / $1,500 family $1,000 individual / $3,000 family $2,500 individual / $7,500 family $5,000 individual / $15,000 family $7,500 individual / $22,500 family $10,000 individual / $30,000 family	$7,000 individual / $14,000 family $8,000 individual / $16,000 family $11,000 individual / $22,000 family $16,000 individual / $32,000 family $21,000 individual / $45,000 family $26,000 individual / $60,000 family
$25 copay for office visit charge[2] 0% for other services[1]	40%[1]
$25 copay for office visit charge[2] 0% for other services[1]	40%[1]
$25 copay for office visit charge[2] 0% for other services[1]	40%[1]
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0%[1]	0%[1]
0%[1]	40%[1]
0%[1]	0%[1]
Not Covered	Not Covered
0%[1]	40%[1]
$25 copay for office visit charge[2] 0% for other services[1]	40%[1]
0%[1] $25 copay for office visit charge[2] 0% for other services[1]	40%[1] 40%[1]
0%[1] $25 copay for office visit charge[2] 0% for other services[1]	40%[1] 40%[1]
0%[1]	40%[1]
0%[1]	40%[1]
0%[1]	40%[1]
0%[1]	40%[1] (Non-network transplant facility), deductible and coinsurance does not apply to out-of-pocket maximums
Unlimited	Unlimited
12 months	12 months

e 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.

* 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: $15/$30/$60/25%

NETWORK YOU PAY	NON-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) **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)	**Retail (30-day supply):** · Tier 1 - 50% with a minimum of $60, no maximum · Tier 2 - 50% with a minimum of $60, no maximum · Tier 3 - 50% with a minimum of $60, no maximum · Tier 4 - 50% with a minimum of $60, no maximum **Mail Service -** Not covered

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

NETWORK YOU PAY	NON-NETWORK YOU PAY
Retail (30-day supply): · 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) **Mail Service (90-day supply):** · 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)	**Retail (30-day supply):** · 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) **Mail Service -** Not covered

PRESCRIPTION DRUG BENEFIT OPTION: $15 GENERIC ONLY

NETWORK YOU PAY	NON-NETWORK YOU PAY
Retail (30-day supply): · Generic Prescription Drugs - $15 per prescription. 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. **Mail Service (90-day supply):** · Generic Prescription Drugs - $30 per prescription. Brand-name prescription drugs are not covered.	**Retail (30-day supply):** · Generic Prescription Drugs - 50% with a minimum of $15, no maximum. Brand-name prescription drugs are not covered. Prescription discounts are not applicable if the provider is non-network. **Mail Service -** Not covered

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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