



W I S C O N S I N

Individual Blue Access 80, 90, 100
Blue Preferred Plus 80 and 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% up to age 6 (Network Only)

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.)

Outpatient Therapy Services

Maximum visits per benefit period for Network and Non-network combined:

- Physical Therapy - 20 visits maximum
- Speech Therapy - 20 visits maximum
- Occupational Therapy - 20 visits maximum
- Spinal Manipulation - no maximum

Mental Health

- Inpatient
- Outpatient

Substance Abuse

- Inpatient
- Outpatient

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

Hospice

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

Human Organ and Tissue Transplant Services

NOTE: Kidney Disease covered up to \$30,000 per person per calendar year

Plan Lifetime Maximum

Preexisting Waiting Period

PLAN 80

PLAN 90

NETWORK YOU PAY	NON-NETWORK YOU PAY	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	\$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
\$35 copay for office visit charge ² 20% for other services ¹	40% ¹	\$35 copay for office visit charge ² 10% for other services ¹	40% ¹
\$35 copay for office visit charge ² 20% for other services ¹	40% ¹	\$35 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
\$35 copay for office visit charge ² 20% for other services ¹	40% ¹	\$35 copay for office visit charge ² 10% for other services ¹	40% ¹
Not Covered Not Covered	Not Covered Not Covered	Not Covered Not Covered	Not Covered Not Covered
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20% ¹	20% ¹	10% ¹	10% 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 certificate

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
\$35 copay for office visit charge ² 0% for other services ¹	40% ¹
\$35 copay for office visit charge ² 0% for other services ¹	40% ¹
\$35 copay for office visit charge ² 0% for other services ¹	40% ¹
0% ¹	40% ¹
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0% ¹	0% ¹
0% ¹	0% ¹
Not Covered	Not Covered
0% ¹	40% ¹
\$35 copay for office visit charge ² 0% for other services ¹	40% ¹
Not Covered Not Covered	Not Covered Not Covered
Not Covered Not Covered	Not Covered Not Covered
0% ¹	40% ¹
0% ¹	0% 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

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.

* Plans 80, 100 are available with the Blue Access network and the Blue Preferred Plus network.

* Plan 90 is available with the Blue Access network.

See your policy for details.

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

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)

NON-NETWORK YOU PAY

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

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)

NON-NETWORK YOU PAY

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

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.

NON-NETWORK YOU PAY

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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