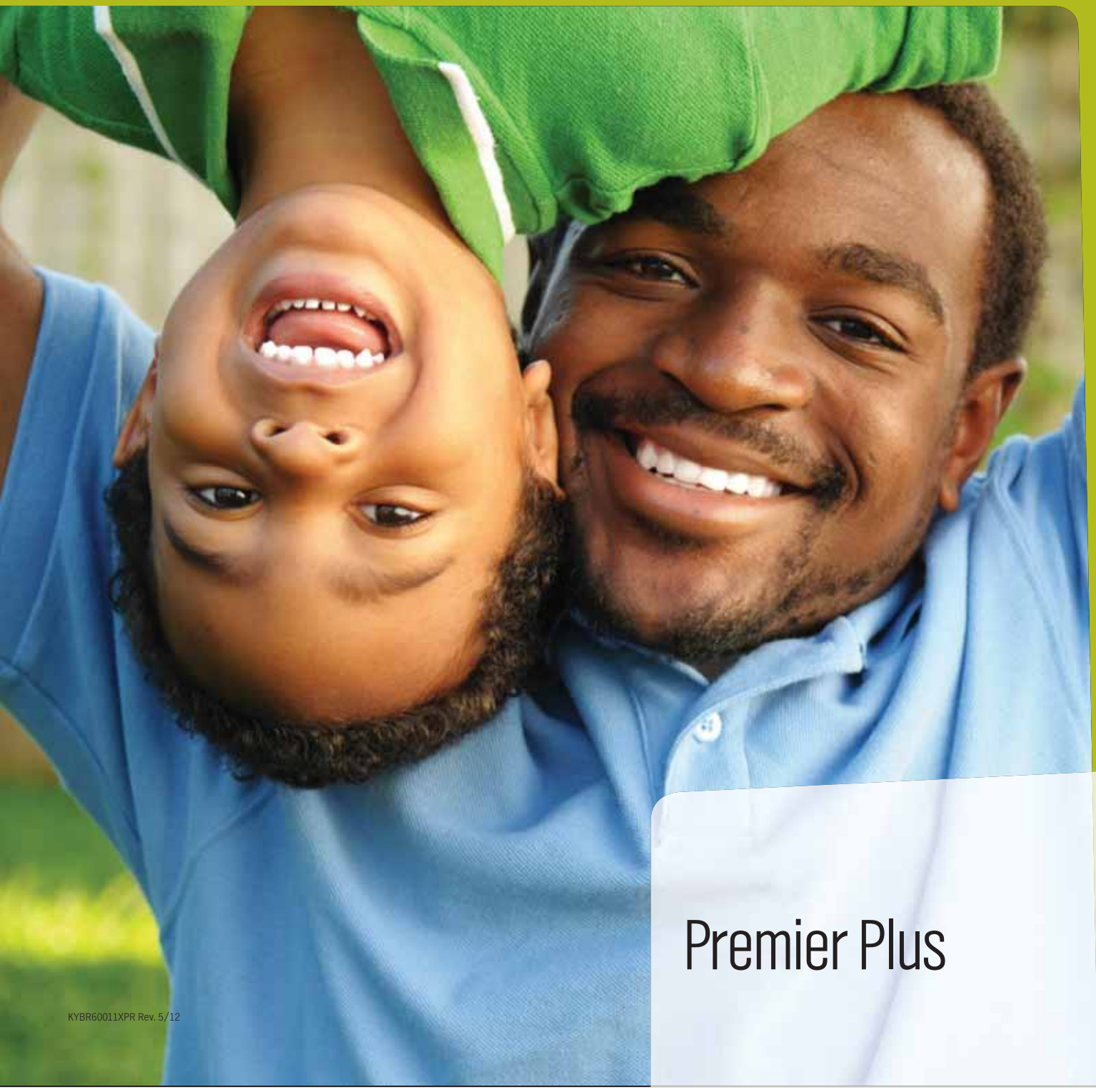
Anthem BlueCross BlueShield

Individual and Family Health Care Plans
for **Kentucky**

Our plans fit your plans



Premier Plus

KYBR60011XPR Rev. 5/12

Why do you need health care coverage?

These days, an average stay in the hospital can cost more than $30,000.** The financial risk you take without health coverage just isn't worth it. Not only does health care coverage help you stay healthy, it also gives you added security, because you know you're protected against the high cost of unexpected medical bills.

Our plans fit the way you live.

In a world that's constantly changing, one thing's for certain: it's important to have health care coverage you can depend on – coverage designed to help fit your budget, and your way of life.

For over 70 years, Anthem Blue Cross and Blue Shield has provided health care coverage and security to our Kentucky neighbors. And we're pleased to offer these same Individual health care plans with added benefits and features of the Patient Protection and Affordable Care Act.

You're in charge of your health and budget, and our Individual health care plans help keep it that way. We still offer a wide range of coverage options as unique as you are. And if you have any questions, we're here to help.

Experience you can rely on

Anthem is committed to helping simplify your life and improving your health. That's why we offer:

- One of the largest provider networks in Kentucky. With nearly 8,000 doctors and specialists and over 100 hospitals* throughout the state, chances are your doctor is in one of our networks.
- A choice of plans to help fit your budget and lifestyle. No matter where you are in life, we've got a plan designed to help fit your health coverage needs, as well as your budget.
- Optional dental and life insurance. To enhance your health, we also offer dental and term life coverage and make it easy to enroll.
- Coverage that travels with you. No matter where life takes you, your health coverage goes with you. And the Blue Cross and Blue Shield Association's BlueCard® program makes it easy to access providers throughout the country.
- ConditionCare to provide one-on-one help from trained professionals in managing chronic conditions like asthma, diabetes, coronary artery disease, chronic obstructive pulmonary disease and heart failure.
- Future Moms, a program designed to help you have a healthy pregnancy. While not maternity coverage, Future Moms provides educational materials, certain screenings and 24/7 phone access to registered nurses.

*BCBSA Provider Data Counts, 2011.

**Based on 2009 weighted national estimates from HCUP National Inpatient Sample (NIS), Agency for Healthcare Research and Quality (AHRQ), based on data collected by Individual states and provided to AHRQ by the states. (Average stay of 4.6 days; average cost to uninsured of $30,655.)

Some definitions so we're all on the same page

Network Discounts: With Anthem, you have access to one of the largest provider networks in the state. These network (or participating) providers have agreed to accept lower costs for their covered services to Anthem members — similar to volume discounts. These negotiated costs help reduce the overall cost of covered medical services, including your share of those costs.

This is true whether you are paying the entire cost for covered services (such as while you are meeting your deductible), or whether we are sharing the cost. With nearly 8,000 doctors and specialists and more than 100 hospitals and other facilites*, chances are your provider already participates. Just visit a network provider to take advantage of the savings. Your costs may be higher when using non-network providers and facilities.

Premiums are the amount of money you pay on a regular basis- once a month, four times a year, twice a year or once a year-to your health coverage company to keep your health benefit plan active. You can't apply what you pay for your premium toward your deductible. Premium amounts are guaranteed for one year and may be changed with 30 days advance written notice.

Cost-Sharing: The costs of medical care today can be staggering. Health care coverage from Anthem can help protect you against these high costs. With most health care coverage, you pay a monthly premium, then you share some of the cost of covered medical care with the company that provides your health care coverage. The level of cost-sharing you choose directly impacts your premium amount. The more you are willing to share in the costs, the lower your premium. With Anthem, you can choose your level of protection and the level of cost-sharing that works best for your health care needs and budget.

Deductible is the amount you have to pay each calendar year for covered services before your health care plan starts paying. For some services, the plan will even begin to pay before the deductible is met. Usually, the higher a plan's deductible, the lower the premium. In some cases, you may also have a separate deductible for certain services such as prescription drugs.

Coinsurance is the percentage of the cost of covered services that you will be responsible for, after your annual deductible is met. With some plans, you have a choice of coinsurance levels. Much like your deductible, selecting a higher coinsurance typically lowers your monthly premium because it increases your share of the cost. Coinsurance does not apply to your deductible.

Copayment is a specific dollar amount you have to pay for certain covered services. Copayments do not apply toward meeting your deductible or out-of-pocket maximum. You are responsible for copayments even after your out-of-pocket maximum is reached.

Out-Of-Pocket Maximum is the total amount of money (not counting your premiums) that you have to pay each year for your health care coverage. Your deductible and coinsurance, for covered services (except those for prescription drugs and non-network Human Organ and Tissue Transplant services) count toward your out-of-pocket maximum. Payments for non-network organ and tissue transplants do not apply toward the out-of-pocket maximum.

Prescription Drugs are medications that must be authorized for use by your doctor. Anthem offers varying levels of prescription drug coverage. Depending on the plan, you may have coverage for generic drugs or generic and brand name drugs.

Generic Drugs are prescription drugs that typically have been in use for some time and can be manufactured and distributed by numerous companies, so their cost is usually much lower. Generic drugs must, by law, contain the same active ingredients as their brand name equivalent and have the same clinical benefit.

Brand Name Drugs are prescription drugs that are manufactured and marketed under a registered name. They are usually patented and may be exclusively offered by certain manufacturers.

Tiers represent a cost level within the generic and brand name prescription drug categories. The prescription drug coverage under your health care plan will differ for each of these tiers. Not all products have this tiering.

- **Tier 1:** Generally includes generic drugs and a few lower cost brand name drugs.
- **Tier 2:** Generally includes higher cost generic and brand name drugs.
- **Tier 3 and 4:** Highest cost brand name drugs.

Formulary is a list of prescription drugs our health care plans cover. They include generic and preferred brand name drugs that have been rigorously reviewed and selected by a committee of practicing doctors and clinical pharmacists for their quality and effectiveness. We've negotiated lower prices on these formulary drugs, so you'll save when your doctor prescribes medication from our formularies. There can be different formularies for different health care plans. Formulary lists can be found at anthem.com.

Health Savings Account (HSA) is a special bank account that can be set up by a member enrolled in a qualified HSA-compatible high deductible health plan if they choose. Contributions to this account can be made with certain tax advantages and funds from the account can be used for qualified health care expenses. See the insert from our preferred banking partner for more details and consult your tax advisor.

*BCBSA Provider Data Counts, 2011.

Premier Plus Is this the right plan for you?

Premier Plus health care plans offer the highest level of benefits we offer for a variety of services. Great for families or for individuals looking for richer benefits, Premier Plus offers the most benefits before the deductible of any plan we offer and richer coverage as well for prescription drugs.

Premier Plus Plan Highlights

Premier Plus offers robust benefits for both routine and unexpected medical care. The lowest levels of coinsurance across all deductibles give Premier Plus added value over other plans we offer.

Features:

- Premier Plus offers benefit options including an unlimited number of Doctors' Office Visits, with predictable copayment, before the deductible.
- Offers a choice of prescription drug coverage options.
- Preventive care benefits that help you focus on staying healthy.

You should know:

- Maternity benefits are available with this plan at an additional cost.
- Premier Plus has our highest level of benefits available, so the premiums are typically more than our other plans.

Prescription Drug Coverage

Premier Plus offers broad prescription drug coverage before the deductible, including benefits for generic and brand name drugs.

You also have the choice to upgrade your prescription drug coverage to remove the separate deductible and have more predictable cost sharing amounts.

See your Benefit Guide for more details.

How to Customize your Premier Plus Plan

With Premier Plus you have some choice and flexibility to change the plan to better meet your needs. Premier Plus offers a choice of:

Deductible: You can usually lower your premium by choosing a higher deductible. Simply choose the deductible and premium combination that works best for you.

Coinsurance: At certain deductible levels, you have a choice of a percentage coinsurance or no coinsurance at all for most services, and coverage at 100%. The zero coinsurance options will increase your levels of coverage but also your premium if you choose it.

Doctor Office Copayment: You can lower your monthly premium cost by removing the doctor office visit copayment and instead apply those visits to your policy deductible. After your deductible is met, you would pay a coinsurance amount for doctor office visits if you choose this option.

Other Optional Coverage: Includes maternity benefits, dental, life insurance, and extended mental health benefits. See your Benefit Guide and the dental and life information in the back of this brochure.

Anthem BlueCross BlueShield

Benefit Guide for Kentucky

Benefits	Premier Plus								
Calendar Year Deductible	**Your Choices**								
Individual NETWORK:	$250	$500	$1,000	$1,500	$2,500	$2,500	$3,500	$5,000	$10,000
Individual NON-NETWORK:	$250	$500	$1,000	$1,500	$2,500	$2,500	$3,500	$5,000	$10,000
Family NETWORK:	$500	$1,000	$2,000	$3,000	$5,000	$5,000	$7,000	$10,000	$20,000
Family NON-NETWORK:	$500	$1,000	$2,000	$3,000	$5,000	$5,000	$7,000	$10,000	$20,000
Network Coinsurance Options	20%	20%	20%	20%	20%	0%	0%	0%	0%
Calendar Year Out-of-Pocket Maximum	**Add Your Chosen Deductible to the Amount Below**								
Individual NETWORK:	$2,500	$2,500	$2,500	$2,500	$2,500	$0	$0	$0	$0
Individual NON-NETWORK:	$7,500	$7,500	$7,500	$7,500	$7,500	$7,500	$7,500	$7,500	$7,500
Family NETWORK:	$5,000	$5,000	$5,000	$5,000	$5,000	$0	$0	$0	$0
Family NON-NETWORK:	$15,000	$15,000	$15,000	$15,000	$15,000	$15,000	$15,000	$15,000	$15,000
How family deductibles and family out-of-pocket maximums work	Each family member has an individual deductible and out-of-pocket maximum. The family deductible and out-of-pocket maximum can be satisfied by 2 or more members. No one person can contribute more than their individual deductible or out-of-pocket maximum.								
Plan Lifetime Maximum	None								

Covered Services	Your Share of Costs (after deductible, unless waived or not subject to deductible)
Doctors' Office Visits	**NETWORK: Office Visit** **$30 Copayment,** deductible waived, for primary care physician; **$40 Copayment,** deductible waived, for specialist **No-Office-Copayment Option (available on $1,500/20% and $2,500/0%) Office Visit: 20% or 0% Coinsurance[1]** **Other Services:** (for all plan deductibles) **20% or 0% Coinsurance[1]** **NON-NETWORK: 40% Coinsurance**
Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.)	**NETWORK: 20% or 0% Coinsurance[1]** **NON-NETWORK: 40% Coinsurance**
Inpatient Services (overnight hospital/facility stays)	**NETWORK: 20% or 0% Coinsurance[1]** **NON-NETWORK: 40% Coinsurance**
Outpatient Services (without overnight hospital/facility stays)	**NETWORK: 20% or 0% Coinsurance[1]** **NON-NETWORK: 40% Coinsurance**
Emergency Room Services	**NETWORK: 20% or 0% Coinsurance[1]** **NON-NETWORK: 20% or 0% Coinsurance[1]**
Preventive Care Services	Includes preventive services recommended by the United States Preventive Services Task Force, including well-child care, immunizations, PSA screenings, Pap tests, mammograms, and more. **NETWORK: 0% Coinsurance,** not subject to deductible **NON-NETWORK: 40% Coinsurance[1]**
Maternity	Not Covered (see Optional Coverage below)
Optional Coverage (at additional cost)	Dental, Life, Maternity (optional maternity rider available for purchase with $2,500 individual/$5,000 family or greater deductible; subject to 12 month waiting period and $3,000 professional services/delivery copayment); Extended Mental Health Rider[2]

Prescription Drug Coverage	Premier Plus
Retail Drugs (and Mail Order Drugs when available)	**Standard Drug Coverage:** Separate $250 per person deductible for Tiers 2, 3 and 4. If Generic is available, member is responsible for the difference in allowable charge between Brand and Generic, plus copayment or coinsurance. **NETWORK:** · **Tier 1 Drugs:** Retail (30 day supply): **$15 Copayment;** Mail Order (90 day supply): **$30 Copayment** · **Tiers 2, 3 and 4:** Greater of **$30 Copayment or 40% Coinsurance** for both Retail (30 day supply) or Mail Order (90 day supply) Tiers 2, 3 and 4: $4,000 annual Prescription Drug out-of-pocket maximum per person. **NON-NETWORK:** · **50% Coinsurance** (minimum $60) per prescription. Mail order not covered.
Optional Drug Coverage (when available)	**Upgrade Drug Coverage:** **NETWORK:** · **Retail Drugs (30 day supply):** Tier 1 **($15 Copayment)**/Tier 2 **($30 Copayment)**/Tier 3 **($60 Copayment)**/Tier 4[3] **(25% Coinsurance)** · **Mail Order Drugs (90 day supply):** Tier 1 **($30 Copayment)**/Tier 2 **($75 Copayment)**/Tier 3 **($150 Copayment)**/Tier 4[3] **(25% Coinsurance)** **NON-NETWORK:** · **Retail Drugs (30 day supply only): 50% Coinsurance** (minimum $60) per prescription. Mail order not covered.
Other Covered Benefits include but are not limited to:	Ambulance, Chiropractic, Durable Medical Equipment, Home Health Care, Hospice Care, Mental Health, Organ Transplants, Rehabilitation Facilities, Skilled Nursing Care, Substance Abuse, Physical Therapy, Occupational Therapy, Speech Therapy, Manipulation Therapy, Vision Exam, Urgent Care

IMPORTANT: This Benefit Guide is intended to be a brief outline of coverage and is not intended to be a legal contract. The entire provisions of benefits, limitations and exclusions are contained in the Contract/Certificate of Coverage. In the event of a conflict between the Contract/Certificate of Coverage and this Benefit Guide, the terms of the Contract/Certificate of Coverage will prevail.

[1] Coinsurance is designated by the plan you choose.

[2] If Extended Mental Health Rider is purchased, Mental Health is covered the same as any other condition. For more information about Mental Health coverage, please see the Coverage Details you should have received with this brochure.

[3] Separate $2,500 annual Prescription Drug out-of-pocket maximum with Tier 4 Drugs.

NOTE: Network and non-network deductibles are separate and do not accumulate towards each other. Network and non-network out-of-pocket maximums are also separate and do not accumulate towards each other.

Give yourself every advantage...

Good health and a bright smile.

Dental Blue® Plans

Regular dental check-ups and cleanings are important to your overall health. That's why we give you the option of adding one of these Dental Blue plans to your health coverage:

1. **Dental Blue Basic 100:** Gives you coverage for the basics, like routine check-ups and fillings. If your dental needs are simple, this may be the right plan for you.
2. **Dental Blue Essential 100:** Includes coverage for the basics, plus services like crowns, bridges, root canals and dentures. If you think you may need major dental work, this is the right plan for you.
3. **Dental Blue Essential 200:** Has basically the same coverage as Essential 100, but this plan also gives you wider choice of network dentists in exchange for a slightly higher cost. If your favorite dentist is in our larger network, this plan may be the best choice for you.

How dental networks help you save

While all three Dental Blue plans allow you to go to any dentist, you'll save the most money when you choose a dentist from your plan's network. There are two Dental Blue networks:

- **Dental Blue 100 network:** This is the value network for our Dental Blue 100 plans. Dental Blue Basic 100 and Essential 100 members can save the most on dental care when they choose a dentist from this network.
- **Dental Blue 200 network:** Includes the entire 100 network plus even more choices of dentists and specialists. Dental Blue Essential 200 members can save the most on dental care when they choose a dentist from this network.

How to choose the dental plan that works best for you.

Use the chart below to compare dental plan benefits side by side.

Plan Names	Dental Blue Basic 100	Dental Blue Essential 100	Dental Blue Essential 200	All Plans*
Networks	Dental Blue 100	Dental Blue 100	Dental Blue 200 (which includes all Dental Blue 100 dentists)	Benefit from negotiated rates at Dental Blue providers.
Preventive and Diagnostic care	100% covered within plan network. Includes routine checkups, X-rays and fluoride applications for children.	100% covered within plan network. Includes Basic 100 services plus space maintainers.		No waiting period; no deductible in or out-of-network; covers two routine cleanings and oral exams per year; molar/bicuspid X-rays; full mouth X-rays covered once every five years.
Minor restorative dental care	80% covered within plan network and pays set amount out-of-network after $50 deductible.* Includes fillings and space maintainers. Extractions not covered.	Pays set amount within plan network and out-of-network after $50 deductible.* Includes fillings and extractions. Space maintainers are considered preventive/diagnostic care.		No waiting period.
Major restorative dental care	Not covered	Pays set amount within plan network and out-of-network after $50 deductible.* Includes crowns, bridges, root canals and dentures.		12-month waiting period with Dental Blue Essential plan options.

*Per member, per calendar year
This is only a summary of Dental Blue benefits. For complete benefit details, please refer to your Individual Dental Contract.

Optional Term Life Insurance

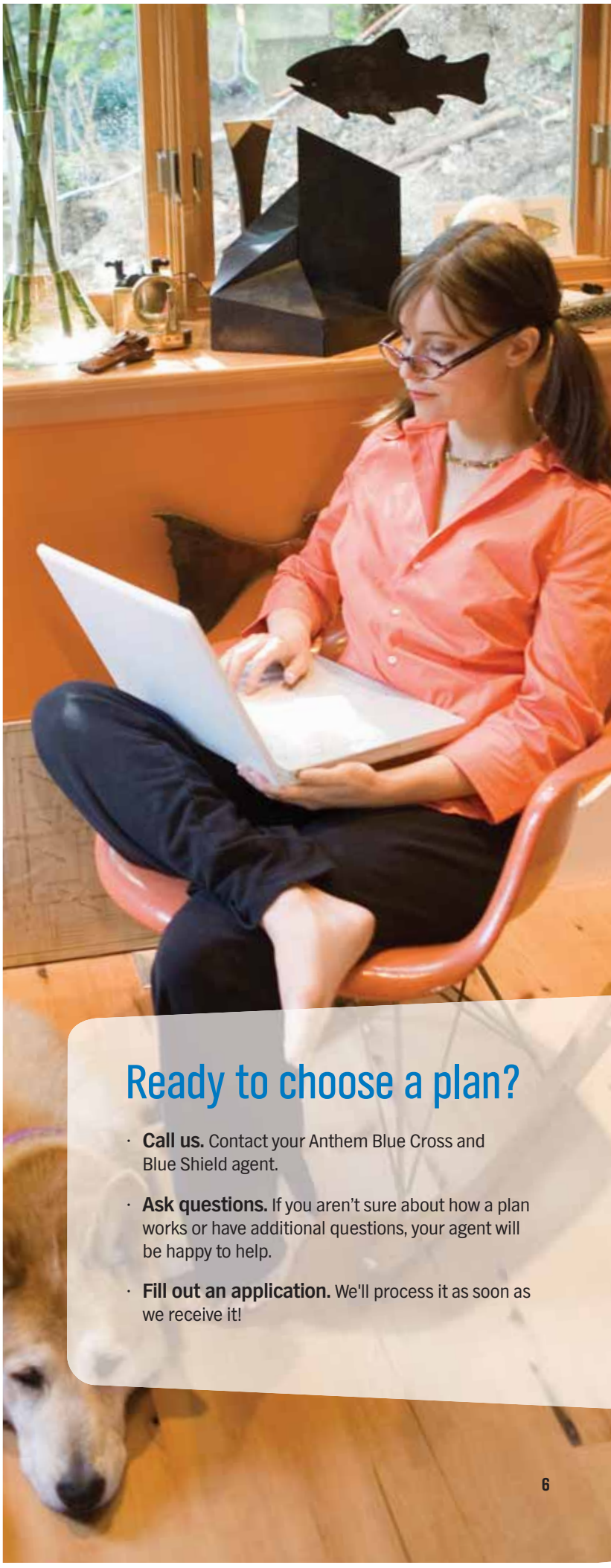
You can add Anthem Blue Preferred® Term Life Insurance to your health coverage. It's easy. There are no medical exams or extra forms to fill out. Simply use your application to apply for coverage.

Term Life Monthly Rates			
Age	**$15,000**	**$25,000**	**$50,000**
1-18	$1.50	$2.50	N/A
19-29	$2.85	$4.75	$9.50
30-39	$3.30	$5.50	$11.00
40-49	$7.50	$12.50	$25.00
50-59	$20.85	$34.75	$69.50
60-64	$29.40	$49.00	$98.00

Additional information

Save time with automatic premium payments

Hate writing checks? After your initial payment, our Electronic Fund Transfer (EFT) program will automatically withdraw funds from your bank account each month to pay for your health plan premium. You'll not only save on postage, you won't have to worry about a lapse in coverage because you forgot to mail in your payment. To sign up, just fill out the billing section of the enrollment application.



Ready to choose a plan?

- **Call us.** Contact your Anthem Blue Cross and Blue Shield agent.
- **Ask questions.** If you aren't sure about how a plan works or have additional questions, your agent will be happy to help.
- **Fill out an application.** We'll process it as soon as we receive it!

Anthem BlueCross BlueShield

Individual and Family Health Care Plans
for Kentucky

Individual health coverage. Your plans. Your choices.

Make sure you have all the facts.

This brochure is only one piece of your plan information. Please make sure you have all the facts about the benefits offered by the plan(s) described — including what's covered, and what isn't. This policy has exclusions, limitations, and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, contact your insurance agent, Anthem, or visit us on the web. You may also see the enclosed Coverage Details. This document should be included with your information kit, or if you have printed this from your computer, it should be at the end of this document. If you don't have this document, be sure to contact your Anthem Sales Representative or Agent.

This brochure is intended as a brief summary of benefits and services; it is not your Contract/Certificate of Coverage. If there is any difference between this brochure and your Contract/Certificate of Coverage, the provisions of the Contract/Certificate of Coverage will prevail. Benefits and premiums are subject to change.

This summary of benefits complies with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

We want you to be satisfied.

If you aren't satisfied with your coverage, you can cancel it within 30 days after you receive your Contract or Certificate of Coverage or have access to it online, whichever is earlier. If you haven't submitted any claims, you'll get a full refund of the premium you paid when coverage is cancelled within the first 30 days. You can view your Contract or Certificate of Coverage online or receive a paper copy of it upon request as outlined in your initial membership letter.

Ready to enroll?

Call your Anthem agent today!

After 9/23/12, to view a Summary of Benefits and Coverage please visit www.healthcare.gov.

Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Kentucky, Inc. Life and Disability products underwritten by Anthem Life Insurance Company. Independent licensees of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Kentucky Coverage Details

Anthem BlueCross BlueShield

Things you need to know before you buy...

SmartSense® Plus, Premier Plus and Lumenos® HSA Plus

Before choosing a health care plan, please review the following information, along with the other materials enclosed.

Who Can Apply?

You can apply for coverage for yourself or with your family. You must be a resident of Kentucky, under the age of 65 and a legal resident of the U.S. Family health coverage includes you, your spouse or domestic partner and any dependent children. Children are covered to the end of the month in which they turn age 26.

Terms of Coverage

- Premiums are guaranteed for 12 months and subject to change with 30 days prior written notice.
- Anthem Blue Cross and Blue Shield has the right to change the provisions of its health benefit plans, including benefits, on the Contract's renewal date with at least 30 days written notice to the subscriber. Changes in Contract provisions required by state or Federal law do not, however, require notice to the member.
- In the event Anthem chooses to discontinue offering a particular health benefit plan, all affected subscribers will receive written notice at least 90 days before the effective date of the termination. All affected subscribers will have the choice to purchase any other health benefit plan currently of that type offered by Anthem in that market.
- The health benefit plan is subject to termination if the member moves out of the service area or is not located within the service area.

What's A Pre-Existing Condition?

For applicants age nineteen (19) and older, our plans cover pre-existing conditions after you've been enrolled in the plan for 12 months. A pre-existing condition is any medical or physical condition you had in the six months right before you enrolled. If you received medical advice, a diagnosis, care or treatment for the condition – or if it was recommended that you do so – that qualifies it as "pre-existing." The pre-existing condition limitation does not apply to applicants under the age nineteen (19).

If you apply for coverage within 63 days of terminating your membership with another "creditable" health care plan, then you can use your prior coverage for credit toward the 12-month waiting period. Anthem Blue Cross and Blue Shield will credit the time you were enrolled on the previous plan.

Access to the MIB

Information regarding your insurability will be treated as confidential. Anthem Blue Cross and Blue Shield or its reinsurers may, however, make a brief report thereon to the MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act.

The address of MIB's Information Office is:
50 Braintree Hill Park, Suite 400
Braintree, MA 02184-8734

Information for consumers about MIB may be obtained on its website at www.mib.com. Anthem Blue Cross and Blue Shield, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

Utilization Management and Case Management

Our Utilization Management (UM) services offer a structured program that monitors and evaluates member care and services. The UM clinical team, which is made up of health care professionals who hold active professional licenses and certificates, perform the prior authorization, concurrent and retrospective review processes explained below. The UM team follows criteria to assist in decisions regarding requests for health care and other covered benefits, and complies with specific timeframes to ensure requests are handled in a timely manner. Our case management services help you to better understand and manage your health conditions.

Prospective Review/Pre-Admission Review

Prospective review (also known as pre-service or pre-admission review) is the process of reviewing a request for a medical procedure or service before it takes place. The review occurs to ensure that: 1) the procedure is medically necessary and 2) the procedure meets your health care plan's specific guidelines prior to being performed. Requests for prospective review may include but are not limited to:

- inpatient hospitalizations
- outpatient procedures
- diagnostic procedures
- therapy services
- durable medical equipment

Prospective review is required for all elective inpatient admissions and certain outpatient services. The review process evaluates medical necessity and the best level of care and assigns expected length of stay if needed.

Concurrent Review

Concurrent review is an ongoing evaluation of a member's hospital stay, as well as ongoing extensions of services that may be needed (such as acute care facilities, skilled nursing facilities, acute rehabilitation facilities, and home health care services). The review includes physicians, member-assigned health care professionals (or member authorized representative) and takes place by telephone, electronically and/or onsite.

Concurrent review uses pre-set decision criteria in order to approve medical care (deemed to be medically necessary) and assign the right level of care for continued medical treatment. Review decisions are based on the medical information obtained at the time of the review. Concurrent review also helps to coordinate care with behavioral health programs.

Retrospective Review

The retrospective review process consists of obtaining information to determine medical necessity as it relates to services provided without

approval or notice ahead of time (e.g., without pre-service notification). Relevant clinical information is required for the retrospective review process. Review decisions are based only on the medical information the doctor or other provider had at the time the member received medical care.

Case Management

Case managers are licensed healthcare professionals who work with you to help you understand your benefits and support your health care needs. The case manager works with you and your doctor to help you better understand and manage your health conditions.

What Our Individual Health Care Plans Do Not Cover

The following Exclusions and Limitations will help you understand what your health care plan does not include before you enroll. These are just some of the plans' limitations and exclusions. Check your Contract or Certificate of Coverage for a complete listing of benefits, exclusions and maximum payment levels.

Medical Exclusions and Limitations

Our plans do not provide benefits for:

- Services, supplies or charges having to do with pre-existing conditions (see "What's A Pre-Existing Condition?") for members age 19 and older
- Charges incurred prior to the effective date of coverage or after the termination date of coverage
- Private duty nursing
- Maternity services, unless an optional rider is purchased for Premier Plus, or as required by law
- Experimental or investigative treatment
- Dental and vision, except as written in your Contract
- Charges above the maximum allowable amount (charges exceeding the amount Anthem recognizes for services)
- Services that are payable under any government program, including but not limited to Medicare Parts A, B and/or D, unless otherwise specified in the Contract or otherwise required by law.
- Care provided by a member of your family
- Educational services
- Comfort and/or convenience items
- Treatment that's primarily intended to improve your appearance
- Weight loss programs or treatment of obesity
- Eyeglasses or contact lenses
- Radial keratotomy or keratomileusis or excimer laser photo
- Sclerotherapy
- Routine foot care
- Artificial insemination, fertilization, infertility drugs or sterilization reversal
- Sex transformation surgery
- Custodial care
- Artificial and mechanical hearts
- Workers' compensation
- Services we determine aren't medically necessary

In addition, our **SmartSense Plus, Premier Plus and Lumenos HSA Plus** plans limit the following outpatient services to 20 visits combined network and non-network:

- Speech therapy
- Physical therapy and/or manipulation therapy
- Occupational therapy

Other limitations of our plans include:

- Home health care services limited to 60 visits
- Optional maternity rider available with Premier Plus is subject to a 12-month waiting period
- For applicants age nineteen (19) and older, pre-existing conditions are subject to a 12-month waiting period
- Inpatient Mental Health and Substance Abuse Services are limited to 10 days per calendar year (includes both network and non-network combined).
- Outpatient Mental Health and Substance Abuse Services are limited to 10 visits per calendar year (includes both network and non-network combined).
- Inpatient and outpatient substance abuse rehabilitation programs are limited to two per lifetime

Note: If Extended Mental Health Rider is purchased, the above Mental Health limits do not apply.

Our Appeal Rights and Confidentiality Policy

If we deny a claim or request for benefits completely or partially, we will notify you in writing. The notice will explain why we denied the claim/request and describe the appeals process. You can appeal decisions that deny or reduce benefits. We encourage you to file appeals right away when you first get an initial decision from us, but we require that you file within six months of getting one. You should send additional information that supports your appeal and state all the reasons why you feel the appeal request should be granted. We will review your appeal and let you know our decision in writing within 30 days of receiving your first appeal.

If you are denied coverage based on medical necessity or experimental/investigative exclusions, you can request that a board-eligible or board-certified specialist review your appeal.

If we deny coverage for reasons other than medical necessity or experimental/investigative reasons, you can also appeal. Please call customer service or check your Contract or Certificate of Coverage for more information on our internal appeal and external review processes. Unless our notice of decision includes a different address, send requests for a review of appeal to:

Anthem Blue Cross and Blue Shield
Appeals Coordinator
P.O. Box 105568
Atlanta, GA 30348-5568

If we uphold our decision throughout the appeals process, you can request a review by the Kentucky Department of Insurance. In addition to the appeals processes we just described, Anthem has adopted a confidentiality policy in Kentucky. This policy includes guidelines regarding the protection of confidential member information and a member's right to access and change information in Anthem's possession. The policy clearly points out when a member needs to sign a release before Anthem can disclose information to a member's provider, spouse or other family members.

We Want You to be Satisfied

If you aren't satisfied with your coverage, you can cancel it within 30 days after you receive your Contract or Certificate of Coverage or have access to it online, whichever is earlier. If you haven't submitted any claims, you'll get a full refund of the premium you paid when coverage is cancelled within the first 30 days. You can view your Contract or Certificate of Coverage online or receive a paper copy of it upon request as outlined in your initial membership letter.

This document is not part of the Contract or Certificate of Coverage. If you are approved for coverage, the Contract or Certificate of Coverage you receive will include all the details of your plan. In the event of a conflict between the information in this document and your Contract or Certificate of Coverage, the terms of your Contract or Certificate of Coverage will

prevail. Read your Contract or Certificate of Coverage carefully. Anthem has the right to rescind, cancel, terminate or reform your coverage based on provisions described in the Contract or Certificate of Coverage.

This summary of benefits complies with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

Selecting health coverage is an important decision.

To assist you, we supply the following for the plans under consideration: Brochure, Benefit Guide, Coverage Details and Enrollment Application. If you did not receive one or more of these materials, please contact your Anthem Blue Cross and Blue Shield agent to request them.

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