

Premier Plan Coverage

OPTION: 0% Coinsurance

CALENDAR YEAR DEDUCTIBLE
CALENDAR YEAR OUT-OF-POCKET LIMIT (includes deductible)

CALENDAR YEAR DEDUCTIBLE
CALENDAR YEAR OUT-OF-POCKET LIMIT (includes deductible)

PLAN LIFETIME MAXIMUM

OPTION: 20% Coinsurance

CALENDAR YEAR DEDUCTIBLE
CALENDAR YEAR OUT-OF-POCKET LIMIT (includes deductible)

CALENDAR YEAR DEDUCTIBLE
CALENDAR YEAR OUT-OF-POCKET LIMIT (includes deductible)

PLAN LIFETIME MAXIMUM

Network					Non-Network				
YOU PAY 0% Coinsurance					YOU PAY 40% Coinsurance				
Individual:	\$2,500	\$3,500	\$5,000	\$10,000	Individual:	\$2,500	\$3,500	\$5,000	\$10,000
	\$2,500	\$3,500	\$5,000	\$10,000		\$10,000	\$11,000	\$12,500	\$17,500
Family:	\$5,000	\$7,000	\$10,000	\$20,000	Family:	\$5,000	\$7,000	\$10,000	\$20,000
	\$5,000	\$7,000	\$10,000	\$20,000		\$20,000	\$22,000	\$25,000	\$35,000
\$7,000,000 per member for network and non-network services combined									

YOU PAY 20% Coinsurance					YOU PAY 40% Coinsurance						
Individual:	\$250	\$500	\$1,000	\$1,500	\$2,500	Individual:	\$250	\$500	\$1,000	\$1,500	\$2,500
	\$2,750	\$3,000	\$3,500	\$4,000	\$5,000		\$7,750	\$8,000	\$8,500	\$9,000	\$10,000
Family:	\$500	\$1,000	\$2,000	\$3,000	\$5,000	Family:	\$500	\$1,000	\$2,000	\$3,000	\$5,000
	\$5,500	\$6,000	\$7,000	\$8,000	\$10,000		\$15,500	\$16,000	\$17,000	\$18,000	\$20,000
\$7,000,000 per member for network and non-network services combined											

Premier Plan Benefits¹

DOCTORS' OFFICE VISITS

PREVENTIVE CARE (includes well-child care, preventive office exams, immunizations, PSA screening, Pap smears, mammograms, colorectal cancer exams, colonoscopy and sigmoidoscopy)

DIAGNOSTIC SERVICES

HOSPITAL (inpatient & outpatient), OUTPATIENT SURGERY

EMERGENCY ROOM SERVICES

VISION

MATERNITY

DENTAL

LIFE

Network		Non-Network	
YOU PAY YOUR SHARE AFTER DEDUCTIBLE, UNLESS WAIVED		YOU PAY YOUR SHARE AFTER DEDUCTIBLE, UNLESS WAIVED	
OFFICE VISIT COPAY: \$30 copay for primary care physician (deductible waived); \$40 copay for specialist (deductible waived)			
OTHER SERVICES: 0% or 20% Coinsurance ²			
PREVENTIVE OFFICE VISIT COPAY: \$30 copay for primary care physician (deductible waived); \$40 copay for specialist (deductible waived)		40% Coinsurance	
PREVENTIVE CARE SERVICES: 20% Coinsurance (deductible waived)			
0% or 20% Coinsurance ²		0% or 20% Coinsurance ²	
\$20 Copay		Cost of exam: All charges except \$35 (deductible waived)	
Not covered		Not covered	
(optional maternity rider available for plans with \$2,500 individual/\$5,000 family or greater deductible; subject to 12-month waiting period)			
Coverage available at additional cost		Coverage available at additional cost	

Premier Plan Drug Coverage

PREMIER INCLUDES COMPREHENSIVE DRUG COVERAGE

PURCHASE OF TIER 1 DRUGS (generic required if available)

PURCHASE OF BRAND AND/OR SPECIALTY DRUGS (tiers 2, 3, and 4) In network subject to a separate deductible and out-of-pocket limit. Note: Specialty injectable drugs only available through Anthem's Specialty Rx network and are not covered out-of-network.

PREMIER DRUG OPTIONAL UPGRADE (\$15 / \$30 / \$60 / 25% Plan)

Note: Tier 4 drugs are subject to a separate \$2500 prescription drug out-of-pocket limit which is combined for retail and mail.

	RETAIL PHARMACY:
	SPECIALTY DRUGS:
	MAIL SERVICE:

Network					Non-Network				
YOU PAY					YOU PAY				
30 day supply: \$15 copay; 90 day mail order supply: \$30 copay					50% Coinsurance (minimum \$60) per prescription Note: Specialty injectable drugs only available through Anthem's Specialty Rx network and are not covered out-of-network.				
Separate \$250 per person deductible for Brand & Specialty drugs. Greater of \$30 copay or 40% coinsurance up to \$4,000 max out-of-pocket. Member is responsible for difference in allowable charge between brand and generic, plus the copayment or coinsurance.									
YOU PAY PER PRESCRIPTION					YOU PAY PER PRESCRIPTION				
Services with copays are not subject to deductible For detailed explanation of drug tiers, see inside.					For detailed explanation of drug tiers, see inside.				
	TIER 1:	TIER 2:	TIER 3:	TIER 4:		TIER 1:	TIER 2:	TIER 3:	TIER 4:
(30-day supply)	\$15	\$30	\$60	25%	(30-day supply)	50% (minimum \$60) per prescription order			
(30-day supply only)	\$15	\$30	\$60	25%	(30-day supply only)	Not covered			
(90-day supply)	\$30	\$75	\$150	25%	(90-day supply)	Not covered			

OTHER COVERED BENEFITS INCLUDE BUT ARE NOT LIMITED TO:

- Ambulance
- Hospice Care
- Skilled Nursing Care
- Chiropractic
- Mental Health
- Speech Therapy
- Durable Medical Equipment
- Organ Transplants
- Therapy Services
- Rehabilitation Facilities
- Urgent Care
- Home Health Care

¹UNLESS OTHERWISE NOTED, ALL BENEFITS ARE SUBJECT TO THE CALENDAR YEAR DEDUCTIBLE.

²COINSURANCE IS DESIGNATED BY THE PLAN YOU CHOOSE.

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 or certificate of coverage. In the event of a conflict between the contract or certificate of coverage and this Premier Benefit Guide, the terms of the contract or certificate of coverage will prevail.

Understanding Premier Coverage

Is your doctor or dentist in
one of our networks?

Go to [anthem.com](https://www.anthem.com) > Find a Doctor

Explanation of Benefits

Deductible: The amount of out-of-pocket expenses you have to pay each year before your health plan kicks in and starts paying for services. Network and non-network deductibles are separate and do not accumulate towards each other.

Coinsurance: The percentage of money you have to pay out of your own pocket for covered services. It's the portion of the bill not paid by your health plan after your deductible has been reached.

Copay (copayment): A specific dollar amount you have to pay out of your own pocket for covered services.

Out-of-pocket limit: The total amount of money (not counting your premiums) you have to pay each year for your health care coverage. Your deductible and coinsurance payments for covered services count toward your out-of-pocket limit. Network and non-network out-of-pocket limits are separate and do not accumulate towards each other.

Premium: 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 insurance company to keep your health plan active. You can't apply what you pay for your premium toward your deductible.

Covered service: This refers to the health care services that are covered by your health plan.

Brand-name drugs: Drugs that are manufactured and marketed under a registered trade name.

Generic drugs: Have the same active ingredients as their brand-name equivalent and provide the same clinical benefits.

Specialty drugs: High cost, scientifically engineered drugs that are usually injected or infused.

Save with tiered pricing

The cost of prescription drugs can be staggering. In fact, prescription drug costs are one of the leading drivers of rising health care costs. Helping control those costs is key to providing affordable health care and health insurance to everyone.

Generic Drugs

You get the best value when you choose generic drugs when available. The cost-sharing design for each plan is different, to help you find a prescription drug benefit that best fits your needs and budget.

Tiered Drugs

Your Benefit Guide chart shows tiered pricing for the Prescription Drug Upgrade Option. Within the brand, generic and specialty drug categories, drugs are sometimes assigned a cost “tier”.

The following explains the four cost tiers:

- **Tier 1 drugs:** Includes mostly preferred generic prescription drugs, but also include some lower cost brand-name drugs considered to have the greatest therapeutic value.
- **Tier 2 drugs:** Includes preferred brand-name and/or generic drugs that are lower-cost and provide greater therapeutic value than comparable brand-name drugs.
- **Tier 3 drugs:** Includes mostly 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 drugs:** 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.

About our network providers

Notice of provider arrangements

Your network provider’s agreement for providing covered services may include financial incentives or risk-sharing relationships based on utilization and quality of services. If you have any questions, please contact Anthem or your provider.

To help you avoid unnecessary out-of-pocket expenses

For some services or supplies (such as prescription drugs), your doctor must receive authorization from Anthem that defines and/or limits the conditions under which the service or supply will be covered. For other services (such as organ transplants), your doctor must certify (and Anthem must approve) that the service is medically necessary and takes place in the appropriate setting. Neither process is a guarantee of coverage.

Using non-network providers

If you receive covered services from a non-network provider, you are responsible for the difference between the actual charge billed for covered services and the maximum allowable amount your plan covers plus any deductible, copayments, coinsurance and charges that are not covered.

For more complete coverage

Dental and Term Life Insurance

You can combine this health plan with Dental Blue® and/or Blue Preferred® Term Life Insurance. Combining coverage is not only easy, it can save you money, too. And you’ll only have to deal with one application, one bill and one monthly premium.

Anthem

Premier

Benefit Guide for Kentucky

Who can apply?

You can apply for Premier coverage for yourself or with your family. You must be a resident of the state in which you are applying, under the age of 65, a legal resident of the U.S. and not currently pregnant. 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 25.

What's a preexisting condition?

Generally, Premier covers preexisting conditions after you've been enrolled in the plan for 12 months. A preexisting 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 "preexisting."

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.

What we do not cover

Premier plans don't provide benefits for services, supplies or charges having to do with preexisting conditions (see "What's a preexisting condition?"); private duty nursing; maternity services, unless optional rider is purchased; experimental or investigative treatment; dental, except as spelled out in your contract; maximum allowable amount (charges exceeding the amount Anthem recognizes for services); care provided by a member of your family; 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; artificial insemination, fertilization, infertility drugs or sterilization reversal; sex transformation surgery; custodial care; artificial and mechanical hearts; workers' compensation; and services we determine aren't medically necessary.

These are just some of Premier plans' limitations and exclusions. Check your contract or certificate of coverage for a complete listing of benefits, exclusions and maximum payment levels.

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 33200, Louisville, Kentucky 40232-3200**

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 Premier 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 brochure is only a summary of Premier benefits and is not a 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 brochure 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.

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