Anthem
Health. **Join In.**

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

Our plans fit your plans

Premier Plus

KYBR60011XPR (5/11)

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 more than 7,500 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, 2010.

**Based on 2008 weighted national estimates from HCUP Nationwide 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 3.8 days; average cost to uninsured of $22,512.)

Why do you need health care coverage?

These days, an average stay in the hospital can cost more than $20,000.** 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.

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 over 7,500 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, 2010.

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.

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
	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
	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
	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
	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	Unlimited

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	Covers all nationally recommended preventive care services, 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
All plans include discounts on non-covered services like teeth whitening and orthodontia. This is only a summary of Dental Blue benefits. For complete benefit details, please refer to your Individual Dental Contract.

Optional Term Life Insurance

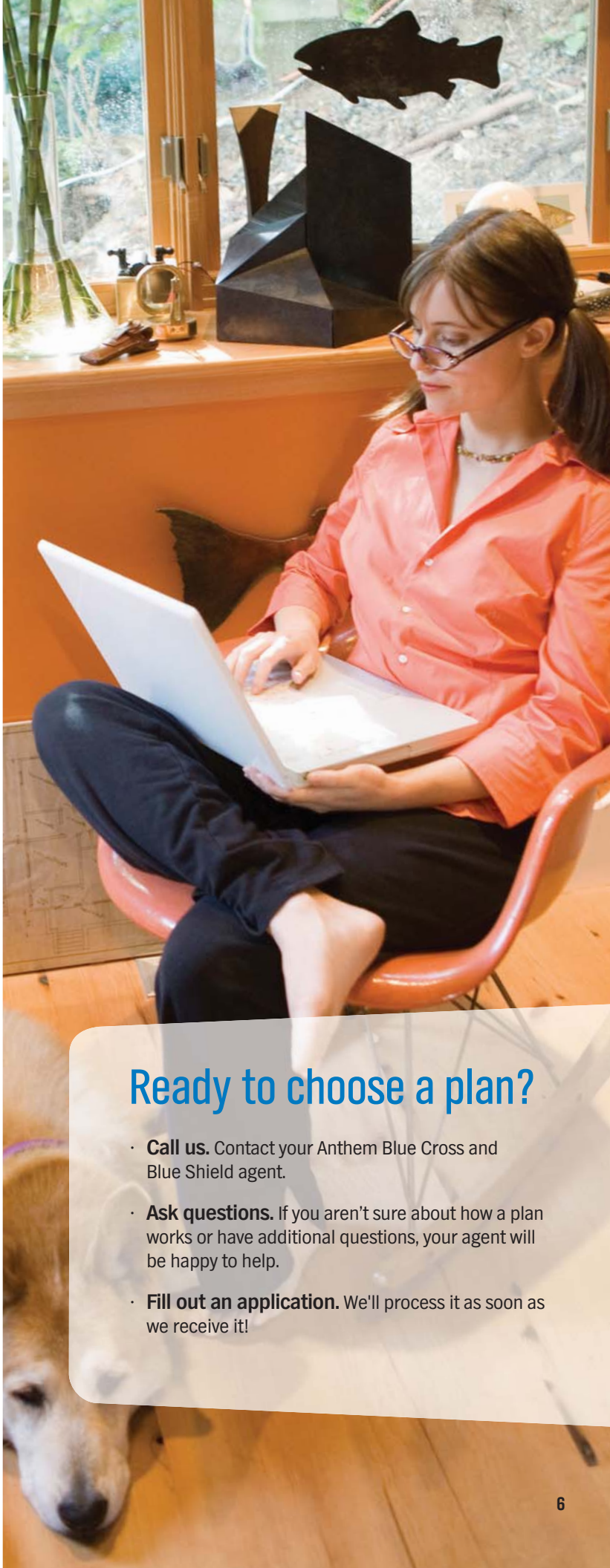
You can add Anthem Blue Preferred® Term Life Insurance to your health coverage. It's easy. There are no medical exams or extra forms to fill out. Simply use your application to apply for coverage.

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
Health. **Join In.**

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!