Anthem

Premier Benefit Guide for Kentucky

Premier Plan Coverage

OPTION: 0% Coinsurance	Network — YOU PAY 0% Coinsurance					Non-Network — YOU PAY 40% Coinsurance				
CALENDAR YEAR DEDUCTIBLE	Individual:	$2,500	$3,500	$5,000	$10,000	Individual:	$2,500	$3,500	$5,000	$10,000
CALENDAR YEAR OUT-OF-POCKET LIMIT *(includes deductible)*		$2,500	$3,500	$5,000	$10,000		$10,000	$11,000	$12,500	$17,500
CALENDAR YEAR DEDUCTIBLE	Family:	$5,000	$7,000	$10,000	$20,000	Family:	$5,000	$7,000	$10,000	$20,000
CALENDAR YEAR OUT-OF-POCKET LIMIT *(includes deductible)*		$5,000	$7,000	$10,000	$20,000		$20,000	$22,000	$25,000	$35,000
PLAN LIFETIME MAXIMUM	$7,000,000 per member for network and non-network services combined									

OPTION: 20% Coinsurance	Network — YOU PAY 20% Coinsurance						Non-Network — YOU PAY 40% Coinsurance					
CALENDAR YEAR DEDUCTIBLE	Individual:	$250	$500	$1,000	$1,500	$2,500	Individual:	$250	$500	$1,000	$1,500	$2,500
CALENDAR YEAR OUT-OF-POCKET LIMIT *(includes deductible)*		$2,750	$3,000	$3,500	$4,000	$5,000		$7,750	$8,000	$8,500	$9,000	$10,000
CALENDAR YEAR DEDUCTIBLE	Family:	$500	$1,000	$2,000	$3,000	$5,000	Family:	$500	$1,000	$2,000	$3,000	$5,000
CALENDAR YEAR OUT-OF-POCKET LIMIT *(includes deductible)*		$5.500	$6,000	$7,000	$8,000	$10,000		$15,500	$16,000	$17,000	$18,000	$20,000
PLAN LIFETIME MAXIMUM	$7,000,000 per member for network and non-network services combined											

Premier Plan Benefits[1]

	Network — YOU PAY YOUR SHARE AFTER DEDUCTIBLE, UNLESS WAIVED	Non-Network — YOU PAY YOUR SHARE AFTER DEDUCTIBLE, UNLESS WAIVED
DOCTORS' OFFICE VISITS	OFFICE VISIT COPAY: $30 copay for primary care physician *(deductible waived)*; $40 copay for specialist *(deductible waived)* OTHER SERVICES: 0% or 20% Coinsurance[2]	40% Coinsurance
PREVENTIVE CARE *(includes well-child care, preventive office exams, immunizations, PSA screening, Pap smears, mammograms, colorectal cancer exams, colonoscopy and sigmoidoscopy)*	PREVENTIVE OFFICE VISIT COPAY: $30 copay for primary care physician *(deductible waived)*; $40 copay for specialist *(deductible waived)* PREVENTIVE CARE SERVICES: 20% Coinsurance *(deductible waived)*	40% Coinsurance
DIAGNOSTIC SERVICES	0% or 20% Coinsurance[2]	40% Coinsurance
HOSPITAL *(inpatient & outpatient)*, OUTPATIENT SURGERY	0% or 20% Coinsurance[2]	40% Coinsurance
EMERGENCY ROOM SERVICES	0% or 20% Coinsurance[2]	0% or 20% Coinsurance[2]
VISION	$20 Copay	Cost of exam: All charges except $35 *(deductible waived)*
MATERNITY	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)	
DENTAL	Coverage available at additional cost	Coverage available at additional cost
LIFE	Coverage available at additional cost	Coverage available at additional cost

Premier Plan Drug Coverage

PREMIER INCLUDES COMPREHENSIVE DRUG COVERAGE	Network — YOU PAY	Non-Network — YOU PAY
PURCHASE OF TIER 1 DRUGS *(generic required if available)*	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.*
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.*	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.	

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.

Network — YOU PAY PER PRESCRIPTION: Services with copays are not subject to deductible. For detailed explanation of drug tiers, see inside.

Non-Network — YOU PAY PER PRESCRIPTION: For detailed explanation of drug tiers, see inside.

	Network	TIER 1:	TIER 2:	TIER 3:	TIER 4:	Non-Network	TIER 1:	TIER 2:	TIER 3:	TIER 4:
RETAIL PHARMACY:	*(30-day supply)*	$15	$30	$60	25%	*(30-day supply)*	50% *(minimum $60)* per prescription order			
SPECIALTY DRUGS:	*(30-day supply only)*	$15	$30	$60	25%	*(30-day supply only)*	Not covered			
MAIL SERVICE:	*(90-day supply)*	$30	$75	$150	25%	*(90-day supply)*	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
- Speech Therapy
- Therapy Services
- Urgent Care

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

[2]COINSURANCE 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.*

MKYBR4892A (02/09)