

Benefit Booklet

(Referred to as "Booklet" in the following pages)

For



UK-Indemnity

07-01-2025



Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que apormonearece en el reverso de su Tarjeta de Identificación.

If you need Spanish-language assistance to understand this document, you may request it at no additional cost by calling Member Services at the number on the back of your Identification Card.

Plan Administered By:

Anthem Health Plans of Kentucky, Inc.

**13550 Triton Park Blvd
Louisville, KY 40223**

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Consolidated Appropriations Act of 2021 Notice

Consolidated Appropriations Act of 2021 (CAA)

The Consolidated Appropriations Act of 2021 (CAA) is a federal law that includes the No Surprises Act as well as the Provider transparency requirements that are described below.

Surprise Billing Claims

Surprise Billing Claims are claims that are subject to the No Surprises Act requirements:

- Emergency Services provided by Out-of-Network Providers;
- Covered Services provided by an Out-of-Network Provider at an In-Network Facility; and
- Out-of-Network Air Ambulance Services.

No Surprises Act Requirements

Emergency Services

As required by the CAA, Emergency Services are covered under your Plan:

- Without the need for Precertification;
- Whether the Provider is In-Network or Out-of-Network;

If the Emergency Services you receive are provided by an Out-of-Network Provider, Covered Services will be processed at the In-Network benefit level.

Note that if you receive Emergency Services from an Out-of-Network Provider, your Out-of-Pocket costs will be limited to amounts that would apply if the Covered Services had been furnished by an In-Network Provider. However, if the treating Out-of-Network Provider determines you are stable, meaning you have been provided necessary Emergency Care such that your condition will not materially worsen and the Out-of-Network Provider determines: (i) that you are able to travel to an In-Network Facility by non-emergency transport; (ii) the Out-of-Network Provider complies with the notice and consent requirement; and (iii) you are in condition to receive the information and provide informed consent, you will be responsible for all charges. This notice and consent exception does not apply if the Covered Services furnished by an Out-of-Network Provider result from unforeseen and urgent medical needs arising at the time of service.

Out-of-Network Services Provided at an In-Network Facility

When you receive Covered Services from an Out-of-Network Provider at an In-Network Facility, your Out-of-Pocket costs will be limited to amounts that would apply if the Covered Service had been furnished by an In-Network Provider. However, if the Out-of-Network Provider gives you proper notice of its charges, and you give written consent to such charges, claims will not be covered. This means you will be responsible for all Out-of-Network charges for those services. This means you will be responsible for all Out-of-Network charges for those services. This Notice and Consent process described below does not apply to Ancillary Services furnished by an Out-of-Network Provider at an In-Network Facility. Your Out-of-Pocket costs for claims for Covered Ancillary Services furnished by an Out-of-Network Provider at an In-Network Facility will be limited to amounts that would apply if the Covered Service had been furnished by an In-Network Provider. Ancillary Services are one of the following services: (A) Emergency Services; (B) anesthesiology; (C) laboratory and pathology services; (D) radiology; (E) neonatology; (F) diagnostic services; (G) assistant surgeons; (H) Hospitalists; (I) Intensivists; and (J) any services set out by the U.S. Department of Health & Human Services. In addition, Anthem will not apply this notice and

consent process to you if Anthem does not have an In-Network Provider in your area who can perform the services you require.

Out-of-Network Providers satisfy the notice and consent requirement as follows:

1. By obtaining your written consent not later than 72 hours prior to the delivery of services; or
2. If the notice and consent is given on the date of the service, if you make an appointment within 72 hours of the services being delivered.

Out-of-Network Air Ambulance Services

When you receive Covered Services from an Out-of-Network Air Ambulance Provider, your Out-of-Pocket costs will be limited to amounts that would apply if the Covered Service had been furnished by an In-Network Air Ambulance Provider.

Your cost shares for Surprise Billing Claims will be calculated based on the Recognized Amount. Any Out-of-Pocket cost shares you pay to an Out-of-Network Provider for either Emergency Services or for Covered Services provided by an Out-of-Network Provider at an In-Network Facility or for Covered Services provided by an Out-of-Network Air Ambulance Service Provider will be applied to your In-Network Out-of-Pocket Limit.

How Cost-Shares Are Calculated

Your cost shares for Emergency Services or for Covered Services received by an Out-of-Network Provider at an In-Network Facility, will be calculated using the median Plan In-Network contract rate that we pay In-Network Providers for the geographic area where the Covered Service is provided. Any Out-of-Pocket cost shares you pay to an Out-of-Network Provider for either Emergency Services or for Covered Services provided by an Out-of-Network Provider at an In-Network Facility will be applied to your In-Network Out-of-Pocket Limit.

Appeals

If you receive Emergency Services from an Out-of-Network Provider or Covered Services from an Out-of-Network Provider at an In-Network Facility, or Out-of-Network Air Ambulance Services and believe those services are covered by the No Surprise Act, you have the right to appeal that claim. If your appeal of a Surprise Billing Claim is denied, then you have a right to appeal the adverse decision to an Independent Review Organization as set out in the "Your Right to Appeal" section of this Benefit Book.

Provider Directories

Anthem is required to confirm the list of In-Network Providers in its Provider Directory every 90 days. If you can show that you received inaccurate information from Anthem that a Provider was In-Network on a particular claim, then you will only be liable for In-Network cost shares (i.e., Copayments, Deductibles, and/or Coinsurance) for that claim. Your In-Network cost-shares will be calculated based upon the Maximum Allowed Amount.

Transparency Requirements

Anthem provides the following information on its website (i.e., www.anthem.com):

- Protections with respect to Surprise Billing Claims by Providers, including information on how to contact states and federal agencies if you believe a Provider has violated the No Surprises Act;

You may also obtain the following information on Anthem's website or by calling Member Services at the phone number on the back of your ID card:

- Cost sharing information for covered items, services, and drugs, as required by the Centers for Medicare & Medicaid Services (CMS); and
- A listing / directory of all In-Network Providers.

In addition, Anthem will provide access through its website to the following information:

- In-Network negotiated rates; and
- Historical Out-of-Network rates.

Notice Regarding Retiree-Only Plans

If this Plan is issued as part of a retiree-only plan, as defined by ERISA §732(a) and IRC §9831(a)(2), the provisions of the Consolidated Appropriations Act of 2021 will not apply, including the provisions regarding the No Surprises Act. In a retiree-only plan, Out-of-Network Providers may bill you for any charges that exceed the Plan's Maximum Allowed Amount. Please contact your Group if you are unsure whether your plan is a retiree-only plan.

Federal Patient Protection and Affordable Care Act Notices

Choice of Primary Care Physician

We generally allow the designation of a Primary Care Physician (PCP). You have the right to designate any PCP who participates in our network and who is available to accept you or your family members. For information on how to select a PCP, and for a list of PCPs, contact the telephone number on the back of your Identification Card or refer to our website, www.anthem.com. For children, you may designate a pediatrician as the PCP.

Access to Obstetrical and Gynecological (ObGyn) Care

You do not need prior authorization from us or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the telephone number on the back of your Identification Card or refer to our website, www.anthem.com.

Additional Federal Notices

Statement of Rights under the Newborns' and Mother's Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Statement of Rights under the Women's Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical benefits provided under this Plan. (See the "Schedule of Benefits" for details.) If you would like more information on WHCRA benefits, call us at the number on the back of your Identification Card.

Coverage for a Child Due to a Qualified Medical Support Order ("QMCSO")

If you or your spouse are required, due to a QMCSO, to provide coverage for your child(ren), you may ask the Employer to provide you, without charge, a written statement outlining the procedures for getting coverage for such child(ren).

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate treatment limitations (day or visit limits) on Mental Health and Substance Use Disorder benefits with day or visit limits on medical and surgical benefits. In general, group health plans offering Mental Health and Substance Use Disorder benefits cannot set day/visit limits on mental health or substance use disorder benefits that are lower than any such day or visit limits for medical and surgical benefits. A plan that does not impose day or visit limits on medical and surgical benefits may not impose such day or visit limits on Mental Health and Substance Use Disorder benefits offered under the Plan. Also, the Plan may not impose Deductibles, Copayment, Coinsurance, and out of pocket expenses on Mental Health and Substance Use Disorder benefits that are more restrictive than the predominant Deductibles, Copayment, Coinsurance and out of pocket expenses applicable to substantially all other medical and surgical benefits in the same classification. Medical Necessity criteria are available upon request.

Special Enrollment Notice

If you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this Plan if you or your Dependents lose eligibility for that other coverage (or if the Employer stops contributing towards your or your Dependents' other coverage). However, you must request enrollment within 31 days after your or your Dependents' other coverage ends (or after the Employer stops contributing toward the other coverage).

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and Your Dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Eligible Subscribers and Dependents may also enroll under two additional circumstances:

- The Subscriber's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- The Subscriber or Dependent becomes eligible for a subsidy (state premium assistance program).

The Subscriber or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

To request special enrollment or obtain more information, call us at the Member Services telephone number on your Identification Card, or contact the Employer.

Introduction

Welcome to Anthem!

This Booklet gives you a description of your benefits while you are enrolled under the health care plan (the "Plan") offered by your Employer. You should read this Booklet carefully to get to know the Plan's main provisions and keep it handy for reference. A thorough understanding of your coverage will allow you to use your benefits wisely. If you have any questions about the benefits shown in this Booklet, please call the Member Services number on the back of your Identification Card.

The Plan benefits described in this Benefit Booklet are for eligible Members only. The health care services are subject to the limitations and Exclusions, Copayments, Deductible, and Coinsurance rules given in this Benefit Booklet. Any group plan or Booklet which you received before will be replaced by this Booklet.

Your Employer has agreed to be subject to the terms and conditions of Anthem's Provider agreements which may include pre-service review and utilization management requirements, coordination of benefits, timely filing limits, and other requirements to administer the benefits under this Plan.

Many words used in the Booklet have special meanings (e.g., Employer, Covered Services, and Medical Necessity). These words are capitalized and are defined in the "Definitions" section. See these definitions for the best understanding of what is being stated. Throughout this Booklet you will also see references to "we", "us", "our", "you", and "your". The words "we", "us", and "our" mean the Claims Administrator or any of its subsidiaries, affiliates, subcontractors, or designees. The words "you" and "your" mean the Member, Subscriber and each covered Dependent.

If you have any questions about your Plan, please be sure to call Member Services at the number on the back of your Identification Card. Also be sure to check the Claims Administrator's website, www.anthem.com for details on how to find a Provider, get answers to questions, and access valuable health and wellness tips.

Important: This is not an insured benefit Plan. The benefits described in this Booklet or any rider or amendments attached hereto are funded by the Employer who is responsible for their payment. Anthem provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

How to Get Language Assistance

The Claims Administrator is committed to communicating with our Members about their health Plan, no matter what their language is. The Claims Administrator employs a language line interpretation service for use by all of our Member Services call centers. Simply call the Member Services phone number on the back of your Identification Card and a representative will be able to help you. Translation of written materials about your benefits can also be asked for by contacting Member Services. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

Identity Protection Services

Identity protection services are available with our Anthem health plans. To learn more about these services, please visit <https://anthemcares.allclearid.com/>.

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Schedule of Benefits

In this section you will find an outline of the benefits included in your Plan and a summary of any Deductibles, Coinsurance, and Copayments that you must pay. Also listed are any Benefit Period Maximums or limits that apply. Please read the "What's Covered" and Prescription Drugs section(s) for more details on the Plan's Covered Services. Read the "What's Not Covered" section for details on Excluded Services.

All Covered Services are subject to the conditions, Exclusions, limitations, and terms of this Booklet including any endorsements, amendments, or riders.

To get benefits under this Plan, you must get Covered Services from an In-Network Provider. Services from an Out-of-Network Provider are not covered, except for Emergency Care, or Authorized Services. Please be sure to contact us if you are not sure if Authorized Services have been approved. Benefits for Covered Services are based on the Maximum Allowed Amount, which is the most the Plan will allow for a Covered Service. Except for Surprise Billing Claims, when you use an approved Out-of-Network Provider you may have to pay the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount in addition to any Coinsurance, Copayments, Deductibles, and non-covered charges. This amount can be substantial. Please read the "Claims Payment" section for more details.

Deductibles, Coinsurance, and Benefit Period Maximums are calculated based upon the Maximum Allowed Amount, not the Provider's billed charges.

Essential Health Benefits provided within this Booklet are not subject to lifetime or annual dollar maximums. Certain non-essential health benefits, however, are subject to either a lifetime and/or dollar maximum.

Essential Health Benefits are defined by federal law and refer to benefits in at least the following categories:

- Ambulatory patient services,
- Emergency services,
- Hospitalization,
- Maternity and newborn care,
- Mental health and substance use disorder services, including behavioral health treatment,
- Prescription drugs,
- Rehabilitative and habilitative services and devices,
- Laboratory services,
- Preventive and wellness services, and
- Chronic disease management and pediatric services, including oral and vision care.

Such benefits shall be consistent with those set forth under the Patient Protection and Affordable Care Act of 2010 and any regulations issued pursuant thereto.

Benefit Period	Plan Year
Dependent Age Limit	To the end of the month in which the child attains age 26.

Deductible	In-Network
Per Member	\$500
Per Family – All other Members combined	\$1,000
<p>When the Deductible applies, you must pay it before benefits begin. See the sections below to find out when the Deductible applies.</p> <p>Copayments and Coinsurance are separate from and do not apply to the Deductible.</p>	

Coinsurance	In-Network
Plan Pays	80%
Member Pays	20%
<p>Reminder: Your Coinsurance will be based on the Maximum Allowed Amount. Except for Surprise Billing Claims, if you use an approved Out-of-Network Provider, you may have to pay Coinsurance plus the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount.</p> <p>Note: The Coinsurance listed above may not apply to all benefits, and some benefits may have a different Coinsurance. Please see the rest of this Schedule for details.</p>	

Out-of-Pocket Limit	In-Network
Per Member	\$4,000
Per Family – All other Members combined	\$8,000
<p>The Out-of-Pocket Limit includes all Deductibles, Coinsurance, and Copayments you pay during a Benefit Period unless otherwise indicated below. It does not include charges over the Maximum Allowed Amount or amounts you pay for non-Covered Services.</p> <p>The Out-of-Pocket Limit does not include amounts you pay for the following benefits:</p> <ul style="list-style-type: none"> • Out-of-Network Human Organ and Tissue Transplant services. • Infertility Services. <p>No one person will pay more than their individual Out-of-Pocket Limit. Once the Out-of-Pocket Limit is satisfied, you will not have to pay any additional Deductibles, Coinsurance, or Copayments for the rest of the Benefit Period.</p>	

Important Notice about Your Cost Shares

In certain cases, if a Provider is paid amounts that are your responsibility, such as Deductibles, Copayments or Coinsurance, such amounts may be collected directly from you. You agree that we, on behalf of the Employer, have the right to collect such amounts from you.

The tables below outline the Plan's Covered Services and the cost share(s) you must pay. In many spots you will see the statement, "Benefits are based on the setting in which Covered Services are received." In these cases you should determine where you will receive the service (i.e., in a doctor's office, at an outpatient hospital facility, etc.) and look up that location to find out which cost share will apply. For

example, you might get physical therapy in a doctor's office, an outpatient hospital facility, or during an inpatient hospital stay. For services in the office, look up "Office and Home Visits." For services in the outpatient department of a hospital, look up "Outpatient Facility Services." For services during an inpatient stay, look up "Inpatient Services."

Benefits	Indemnity	Out-of-Network
Acupuncture	See "Therapy Services."	Not covered
Allergy Services	Benefits are based on the setting in which Covered Services are received.	Not covered
Ambulance Services (Ground, Air and Water) Emergency Services For ground or water ambulance services, Out-of-Network Providers may also bill you for any charges that exceed the Plan's Maximum Allowed Amount. This does not apply to air ambulance services. . For air ambulance services, Out-of-Network Providers cannot bill you for more than your applicable In-Network Deductible, Coinsurance, and/or Copayment. Important Note: All scheduled ambulance services for non-Emergency transfers, except transfers from one acute Facility to another, must be approved through precertification. Please see "Getting Approval for Benefits" for details.	20% Coinsurance after Deductible	
Ambulance Services (Ground, Air, and Water) Non-Emergency Services For ground or water ambulance services, Out-of-Network Providers may also bill you for any charges that exceed the Plan's Maximum Allowed Amount. This does not apply to air ambulance services. For air ambulance services, Out-of-Network Providers cannot bill you for more than your applicable In-Network Deductible, Coinsurance, and/or Copayment. Important Note: All scheduled ambulance services for non-Emergency transfers, except transfers from one acute Facility to another, must be approved through precertification. Please see "Getting Approval for Benefits" for details. Benefits for non-Emergency ambulance services will be limited to \$50,000 per occurrence if an Out-of-Network Provider is used.	20% Coinsurance after Deductible	
Autism Services Unlimited, Covered age 1-21 ABA therapy is considered autism therapy, but a covered person cannot combine ABA therapy with respite care. Precertification is required. ABA Therapy Unlimited, Covered age 1-21	20% Coinsurance after Deductible	Not covered
	20% Coinsurance after Deductible	Not covered

Benefits	Indemnity	Out-of-Network
<p>ABA therapy is considered autism therapy, but a covered person cannot combine ABA therapy with respite care. Precertification is required.</p> <p>Autism Respite Care Unlimited, Covered age 2-21</p> <p>Respite care cannot be combined with ABA therapy.</p> <p>Note: All claims for ABA Respite Care will be paid at the in-network benefit level and based on Anthem’s Allowable charge. The allowable charge could be lower than the billed charge and the member would be responsible for the difference between the allowable and billed charge and that difference would not apply toward the out-of-pocket maximum.</p> <p>Note: Therapy services (example: PT/OT/ST) with Autism diagnosis, apply to the Therapy Service Visit Max and not toward the ABA Therapy. PT/OT/ST will diagnosis of Autism is not an unlimited visit and the visit limit max does apply.</p>	20% Coinsurance after Deductible	Not covered
Behavioral Health Services	Please see the rest of this Schedule for the cost shares that apply in each setting.	Not covered
Cardiac Rehabilitation	See “Therapy Services.”	Not covered
<p>Cellular and Gene Therapy Services</p> <ul style="list-style-type: none"> • Precertification required 	See the “Human Organ and Tissue Transplant (Bone Marrow / Stem Cell), Cellular and Gene Therapy Services” section later in this Schedule.	Not Covered
Chemotherapy	Benefits are based on the setting in which Covered Services are received.	Not covered
Chiropractor Services	See “Therapy Services.”	Not covered
Clinical Trials	Benefits are based on the setting in which Covered Services are received.	Not covered
Congenital Defects and Birth Abnormalities	Benefits are based on the setting in which Covered Services are received.	Not covered

Benefits	Indemnity	Out-of-Network
<p>Dental Services</p> <p>(Limited to services for accidental injury, for certain Members requiring hospitalization or general anesthesia, or to prepare the mouth for certain medical treatments)</p>	<p>Benefits are based on the setting in which Covered Services are received.</p>	<p>Not covered</p>
<p>Diabetes Equipment, Education, and Supplies</p> <p>Screenings for gestational diabetes are covered under "Preventive Care."</p> <p>Benefits for diabetic education are based on the setting in which Covered Services are received.</p> <p>Barnstable Brown Diabetes Prevention Program – only covered for the following codes: 0403T as a counseling service (ICD-10Z71.9): Enrollment Visit: CPT code 0403T with ICD-10 Z71.9; Sessions 1-4: CPT Code 0403T TF with ICD-10 Z71.9; Sessions 5-9: CPT Code 0403T TG with ICD-10 Z71.9; Participant Progress (loses 5-8% weight): CPT Code 0403T TS with ICD-10 Z71.9; Participant Progress (loses 9% or higher weight): CPT Code 0403T TT with ICD-10 Z71.9</p>	<p>20% Coinsurance after Deductible</p>	<p>Not covered</p>
<p>Diagnostic Services</p> <ul style="list-style-type: none"> • CT Lung Screening • Other Diagnostic Services 	<p>No Copayment, Deductible, or Coinsurance</p> <p>Benefits are based on the setting in which Covered Services are received.</p>	<p>Not covered</p> <p>Not covered</p>
<p>Dialysis</p>	<p>Benefits are based on the setting in which Covered Services are received.</p>	<p>Not covered</p>
<p>Durable Medical Equipment (DME), Medical Devices, and Supplies</p> <ul style="list-style-type: none"> • Durable Medical Equipment* • Orthotics Foot and Shoe (only covered with diabetic diagnosis) 	<p>20% Coinsurance after Deductible</p> <p>20% Coinsurance after Deductible</p>	<p>Not covered</p> <p>Not covered</p>

Benefits	Indemnity	Out-of-Network
<ul style="list-style-type: none"> Prosthetics Appliances (external)** Including Cochlear Implants and Bone Anchored Hearing Aids 	20% Coinsurance after Deductible	Not covered
<ul style="list-style-type: none"> Medical and Surgical Supplies* 	20% Coinsurance after Deductible	Not covered
<p>The cost-shares listed above apply when your Provider submits separate bills for the equipment or supplies.</p>		
<p>*Diabetic equipment and supplies are covered under the "Diabetic Equipment, Education and Supplies" section of this Schedule. Benefits for mastectomy supplies and prosthetics are subject to the Plan's regular Coinsurance.</p>		
<p>Hearing aids are limited to one per ear every 36 months for Members under age 18.</p>	20% Coinsurance after Deductible	Not covered
<p>Wigs Needed After Cancer Treatment Benefit Maximum</p>	One wig per Benefit Period	Not covered
<ul style="list-style-type: none"> Continuous Glucose Monitor 	20% Coinsurance after Deductible	Not covered
<p>The Plan's reimbursement for durable medical equipment, orthotics, prosthetics, devices and supplies, hearing aids and wigs will be based on the Maximum Allowed Amount for a standard item that is Medically Necessary to meet your needs. If you choose to purchase an item with features that exceed what is Medically Necessary, benefits will be limited to the Maximum Allowed Amount for the standard item, and you will be required to pay any costs that exceed the Maximum Allowed Amount. Please check with your Provider or contact us if you have questions about the Maximum Allowed Amount.</p>		
<p>Emergency Room Services</p>		
<p>Emergency Room</p>		
<ul style="list-style-type: none"> Emergency Room Facility Charge 	\$100 Copayment per visit then 20% Coinsurance Copayment waived if admitted	
<ul style="list-style-type: none"> Emergency Room Doctor Charge (ER physician, radiologist, anesthesiologist, surgeon) 	20% Coinsurance	
<ul style="list-style-type: none"> Emergency Room Doctor Charge (Mental Health / Substance Use Disorder) 	20% Coinsurance	
<ul style="list-style-type: none"> Other Facility Charges (including diagnostic x-ray and lab services, medical supplies) 	20% Coinsurance	
<ul style="list-style-type: none"> Advanced Diagnostic Imaging (including MRIs, CAT scans) 	20% Coinsurance	

Benefits	Indemnity	Out-of-Network
<ul style="list-style-type: none"> • Non-Emergency Room Facility Charge • Non-Emergency Room Doctor Charge (ER physician, radiologist, anesthesiologist, surgeon) 	<p>20% Coinsurance</p> <p>20% Coinsurance</p>	
<p>As described in the “Consolidated Appropriations Act of 2021 Notice” at the front of this Booklet, for Emergency Services Out-of-Network Providers may only bill you for any applicable Copayments, Deductible and Coinsurance and may not bill you for any charges over the Plan’s Maximum Allowed Amount until the treating Out-of-Network Provider has determined you are stable and followed the notice and consent process. Please refer to the Notice at the beginning of this Booklet for more details.</p>		
<p>Gender Affirming Services</p> <p>Precertification required for surgical services</p>	<p>Covered, as approved by us, up to \$200 per procedure In-Network only.</p>	<p>Not covered</p>
<p>Habilitative Services</p>	<p>Benefits are based on the setting in which Covered Services are received.</p> <p>See “Therapy Services” for details on Benefit Maximums.</p>	<p>Not covered</p>
<p>Home Health Care</p> <ul style="list-style-type: none"> • Home Health Care Visits from a Home Health Care Agency (Including intermittent skilled nursing services) • Home Dialysis • Home Infusion Therapy / Chemotherapy • Specialty Prescription Drugs for Infusion/Injection - Other than Chemotherapy • Other Home Health Care Services / Supplies <p>Home Health Care Benefit Maximum</p>	<p>20% Coinsurance after Deductible</p> <p>20% Coinsurance after Deductible</p> <p>20% Coinsurance after Deductible</p> <p>20% Coinsurance after Deductible</p> <p>20% Coinsurance after Deductible</p> <p>100 visits per Benefit Period The limit includes Therapy Services (e.g., physical, speech, occupational, cardiac and pulmonary rehabilitation) given as part of the Home Care benefit.</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p> <p>Not covered</p> <p>Not covered</p> <p>Not covered</p>

Benefits	Indemnity	Out-of-Network
The limit does not apply to Home Infusion Therapy or Home Dialysis.		
Home Infusion Therapy	See "Home Health Care."	Not covered
Hospice Care		
• Home Hospice Care	20% Coinsurance after Deductible	Not covered
• Bereavement	20% Coinsurance after Deductible	Not covered
• Inpatient Hospice	20% Coinsurance after Deductible	Not covered
• Outpatient Hospice	20% Coinsurance after Deductible	Not covered
• Respite Care	20% Coinsurance after Deductible	Not covered
<p>This Plan's Hospice benefit will meet or exceed Medicare's Hospice benefit. If you use an Out-of-Network Provider, that Provider may also bill you for any charges over Medicare's Hospice benefit unless your claim involves a Surprise Billing Claim.</p>		
Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services	Please see the separate summary later in this section.	Not covered
Infertility Services	See "Maternity and Reproductive Health Services."	Not covered
Inpatient Services		
Facility Room & Board Charge:		
• Hospital / Acute Care Facility	20% Coinsurance after Deductible	Not covered
Benefit Maximum for Newborn 100% Human Diet	Unlimited	Not covered
• Skilled Nursing Facility	20% Coinsurance after Deductible	Not covered
• Rehabilitation	20% Coinsurance after Deductible	Not covered
Rehabilitation Services (Includes Services in an Outpatient Day Rehabilitation Program) Benefit Maximum	Unlimited	Not covered

Benefits	Indemnity	Out-of-Network
Skilled Nursing Facility Benefit Maximum	100 days per Benefit Period	Not covered
• Mental Health / Substance Use Disorder Facility	20% Coinsurance after Deductible	Not covered
• Residential Treatment Center	20% Coinsurance after Deductible	Not covered
Ancillary Services	20% Coinsurance after Deductible	Not covered
Doctor Services when billed separately from the Facility for:		
• General Medical Care / Evaluation and Management (E&M)	20% Coinsurance after Deductible	Not covered
• Surgery	20% Coinsurance after Deductible	Not covered
• Maternity	20% Coinsurance after Deductible	Not covered
• Mental Health / Substance Use Disorder Services	20% Coinsurance after Deductible	Not covered
Mammograms (Outpatient)		
• Diagnostic mammograms	No Copayment, Deductible, or Coinsurance	Not covered
• Routine mammograms	See "Preventive Care."	
Maternity and Reproductive Health Services		
• Maternity Visits (Global fee for the ObGyn's prenatal, postnatal, and delivery services)	20% Coinsurance after Deductible	Not covered
• Inpatient Services (Delivery)	See "Inpatient Services."	Not covered
• Infertility Services	Benefits are based on the setting in which Covered Services are received.	Not covered
• Infertility Benefit Maximum	\$10,000 per Lifetime This Maximum applies to all medical infertility treatments. This includes all 4 programs plus \$5,000 RX through the Pharmacy Benefit.	

Benefits	Indemnity	Out-of-Network
<ul style="list-style-type: none"> Sterilization Services <p>Note: Per KRS 304.17A-139 (3) waive the deductible for the first 31-days of birth for routine and sick newborns.</p> <p>Note: Infertility services must be through WINFertility.</p>	20% Coinsurance after Deductible	Not covered
<p>Mental Health and Substance Use Disorder Services</p>	Please see the rest of this Schedule for the cost shares that apply in each setting.	Not covered
<p>Occupational Therapy</p>	See "Therapy Services."	Not covered
<p>Office and Home* Visits</p>		
<p>Home visits are not the same as Home Health Care. For Home Health Care benefits please see the "Home Health Care" section.</p>		
<p>If Preventive Care is provided during a Virtual Visit, it will be covered under the "Preventive Care" benefit, as required by law. Please refer to that section for details.</p>		
<p>If you have an office visit with your PCP or SCP at an Outpatient Facility (e.g., Hospital or Ambulatory Surgery Center), benefits for Covered Services will be paid under the "Outpatient Facility Services" section later in this Schedule. Please refer to that section for details on the cost shares (e.g., Deductibles, Copayments, Coinsurance) that will apply.</p>		
<ul style="list-style-type: none"> Primary Care Physician / Provider (PCP) (Including In-Person and/or Virtual Visits) 	<p>In-Person Visits: 20% Coinsurance after Deductible</p> <p>Virtual Visits: 20% Coinsurance after Deductible</p>	Not covered
<ul style="list-style-type: none"> Mental Health and Substance Use Disorder Provider (including In-Person and/or Telehealth / Virtual Visits) 	<p>In-Person Visits: 20% Coinsurance after Deductible</p> <p>Virtual Visits: 20% Coinsurance after Deductible</p>	Not covered
<ul style="list-style-type: none"> Specialty Care Physician / Provider (SCP) (including In-Person and/or Virtual Visits) 	<p>In-Person Visits: 20% Coinsurance after Deductible</p> <p>Virtual Visits: 20% Coinsurance after Deductible</p>	Not covered
<ul style="list-style-type: none"> Retail Health Clinic Visit 	20% Coinsurance after Deductible	Not covered
<ul style="list-style-type: none"> Virtual Visits for Specialty Care Services from our Online Provider, LiveHealth Online (whether accessed directly or through our mobile app, 	20% Coinsurance after Deductible	Not covered

Benefits	Indemnity	Out-of-Network
website, or Anthem-enabled device)		
<ul style="list-style-type: none"> Virtual Visits from our Online Provider, LiveHealth Online (whether accessed directly or through our mobile app, website, or Anthem-enabled device) – Includes Medical Services, Mental Health & Substance Use Disorder Virtual Visits 	No Copayment, Deductible, or Coinsurance	Not covered
<ul style="list-style-type: none"> Virtual Visits from our Online Provider, LiveHealth Online (whether accessed directly or through our mobile app, website, or Anthem-enabled device) – Includes Dermatology Services – Virtual Specialist Visit 	20% Coinsurance after Deductible	Not covered
<ul style="list-style-type: none"> Medical Chats and Virtual Visits (Including Primary Care) from our Online Provider, K Health, through its affiliated Provider groups, via our mobile app, website, or Anthem-enabled device 	20% Coinsurance after Deductible	Not covered
<ul style="list-style-type: none"> Counseling – Includes Family Planning 	20% Coinsurance after Deductible	Not covered
<ul style="list-style-type: none"> Nutritional Counseling for Eating Disorders (Mental Health) 	20% Coinsurance after Deductible	Not covered
<ul style="list-style-type: none"> Allergy Testing 	20% Coinsurance after Deductible	Not covered
<ul style="list-style-type: none"> Shots / Injections (other than allergy serum) 	20% Coinsurance after Deductible	Not covered
<p>Hyaluronan injections (J7321-J7328) are covered and should bypass medical policy.</p>		
<ul style="list-style-type: none"> Allergy Shots / Injections (including allergy serum) 	20% Coinsurance after Deductible	Not covered
<ul style="list-style-type: none"> Diagnostic Lab 	20% Coinsurance after Deductible	Not covered
<ul style="list-style-type: none"> Diagnostic X-ray 	20% Coinsurance after Deductible	Not covered

Benefits	Indemnity	Out-of-Network
• Other Diagnostic Tests (including hearing and EKG)	20% Coinsurance after Deductible	Not covered
• Hearing Evaluations (non-preventive)	20% Coinsurance after Deductible	Not covered
• Vision Evaluations (non-preventive)	20% Coinsurance after Deductible	Not covered
• Advanced Diagnostic Imaging (MRI/MRA/SPECT/PET/CT)	20% Coinsurance after Deductible	Not covered
• Office Surgery (including anesthesia)	20% Coinsurance after Deductible	Not covered
• Therapy Services:		
– Chiropractic / Manipulative Therapy* Limited to codes 99202/98940/98941/98942	20% Coinsurance after Deductible	Not covered
– Osteopathic Manipulative Therapy*	20% Coinsurance after Deductible	Not covered
– Physical Therapy*	20% Coinsurance after Deductible	Not covered
– Occupational Therapy*	20% Coinsurance after Deductible	Not covered
– Speech Therapy	20% Coinsurance after Deductible	Not covered
– Dialysis	20% Coinsurance after Deductible	Not covered
– Radiation / Chemotherapy / Respiratory Therapy	20% Coinsurance after Deductible	Not covered
– Cardiac Rehabilitation	20% Coinsurance after Deductible	Not covered
– Pulmonary Therapy	20% Coinsurance after Deductible	Not covered
– Pool Therapy/Exercise Hydrotherapy	20% Coinsurance after Deductible	Not covered
– Infusion Therapy	20% Coinsurance after Deductible	Not covered
– Music Therapy (CPT 97110, 97112, 97116, 97150, 97530, 97535, 97537, 97139, 97532, 97533, 97799, 96105, 96110, 96111, 92506, 96150-96155 only)	20% Coinsurance after Deductible	Not covered
– Acupuncture	20% Coinsurance after Deductible	Not covered
See “Therapy Services” for details on Benefit Maximums.		

Benefits	Indemnity	Out-of-Network
<ul style="list-style-type: none"> • Prescription Drugs Administered in the Office (other than allergy serum) <p>Note: Non-Diabetic Nutritional Counseling is not covered with the exception of Nutritional Counseling for HCR or for Behavioral Health conditions. When part of HCR services refer to Preventive Care Benefits.</p> <p>Note: Audiology tests - Diagnosis codes F80.1, F80.9, H90.3, Z01.10, Z01.110, and Z96.21 are covered when billed with one of the following procedure codes: 92552, 92555, 92556, 92567, 92579, 92582, 92583, 92585, 92587, 92588, 92626.</p>	20% Coinsurance after Deductible	Not covered
Orthotics	See “Durable Medical Equipment (DME), Medical Devices, and Supplies.”	Not covered
Outpatient Facility Services		
<ul style="list-style-type: none"> • Facility Surgery Charge 	20% Coinsurance after Deductible	Not covered
<ul style="list-style-type: none"> • Facility Surgery Lab 	20% Coinsurance after Deductible	Not covered
<ul style="list-style-type: none"> • Facility Surgery X-ray 	20% Coinsurance after Deductible	Not covered
<ul style="list-style-type: none"> • Ancillary Services 	20% Coinsurance after Deductible	Not covered
<ul style="list-style-type: none"> • Doctor Surgery Charges 	20% Coinsurance after Deductible	Not covered
<ul style="list-style-type: none"> • Other Doctor Charges (including Anesthesiologist, Pathologist, Radiologist, Surgical Assistant) 	20% Coinsurance after Deductible	Not covered
<ul style="list-style-type: none"> • Other Facility Charges (for procedure rooms) 	20% Coinsurance after Deductible	Not covered
<ul style="list-style-type: none"> • Mental Health / Substance Use Disorder Outpatient Facility Services (Partial Hospitalization Program / Intensive Outpatient Program) 	20% Coinsurance after Deductible	Not covered
<ul style="list-style-type: none"> • Mental Health / Substance Use Disorder Outpatient Facility Provider Services (e.g., Doctor and other professional Providers in a Partial Hospitalization Program / Intensive Outpatient Program) 	20% Coinsurance after Deductible	Not covered
<ul style="list-style-type: none"> • Shots / Injections (other than allergy serum) 	20% Coinsurance after Deductible	Not covered

Benefits	Indemnity	Out-of-Network
Hyaluronan injections (J7321-J7328) are covered and should bypass medical policy.		
• Allergy Shots / Injections (including allergy serum)	20% Coinsurance after Deductible	Not covered
• Diagnostic Lab	20% Coinsurance after Deductible	Not covered
• Diagnostic X-ray	20% Coinsurance after Deductible	Not covered
• Other Diagnostic Tests (EKG, EEG etc.)	20% Coinsurance after Deductible	Not covered
• Hearing Evaluations (non-preventive)	20% Coinsurance after Deductible	Not covered
• Vision Evaluations (non-preventive)	20% Coinsurance after Deductible	Not covered
• Advanced Diagnostic Imaging (MRI/MRA/SPECT/PET/CT)	20% Coinsurance after Deductible	Not covered
• Therapy:		
– Chiropractic / Manipulative Therapy * Limited to codes 99202/98940/98941/98942	20% Coinsurance after Deductible	Not covered
– Osteopathic Manipulative Therapy*	20% Coinsurance after Deductible	Not covered
– Physical Therapy*	20% Coinsurance after Deductible	Not covered
– Occupational Therapy*	20% Coinsurance after Deductible	Not covered
– Speech Therapy	20% Coinsurance after Deductible	Not covered
– Radiation / Chemotherapy / Respiratory Therapy	20% Coinsurance after Deductible	Not covered
– Dialysis	20% Coinsurance after Deductible	Not covered
– Cardiac Rehabilitation	20% Coinsurance after Deductible	Not covered
– Pulmonary Therapy	20% Coinsurance after Deductible	Not covered
– Pool Therapy/Exercise Hydrotherapy	20% Coinsurance after Deductible	Not covered
– Infusion Therapy	20% Coinsurance after Deductible	Not covered
– Music Therapy (CPT 97110, 97112, 97116, 97150, 97530, 97535, 97537, 97139, 97532, 97533, 97799, 96105,	20% Coinsurance after Deductible	Not covered

Benefits	Indemnity	Out-of-Network
<p>96110, 96111, 92506, 96150-96155 only)</p> <ul style="list-style-type: none"> - Acupuncture <p>See "Therapy Services" for details on Benefit Maximums.</p> <ul style="list-style-type: none"> • Prescription Drugs Administered in an Outpatient Facility (other than allergy serum) <p>Note: Audiology tests - Diagnosis codes F80.1, F80.9, H90.3, Z01.10, Z01.110, and Z96.21 are covered when billed with one of the following procedure codes: 92552, 92555, 92556, 92567, 92579, 92582, 92583, 92585, 92587, 92588, 92626.</p>	<p>20% Coinsurance after Deductible</p> <p>20% Coinsurance after Deductible</p>	<p>Not covered</p> <p>Not covered</p>
Physical Therapy	See "Therapy Services."	Not covered
Preventive Care	No Copayment, Deductible, or Coinsurance	Not covered
<p>Preventive Care for Chronic Conditions (per IRS guidelines)</p> <ul style="list-style-type: none"> • Prescription Drugs • Medical items, equipment and screenings <p>Please see the "What's Covered" section for additional detail on IRS guidelines.</p>	<p>Please refer to the "Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits" section.</p> <p>No Copayment, Deductible, or Coinsurance</p>	<p>Not covered</p> <p>Not covered</p>
Prosthetics	See "Durable Medical Equipment (DME), Medical Devices, and Supplies."	Not covered
Pulmonary Therapy	See "Therapy Services."	Not covered
Radiation Therapy	See "Therapy Services."	Not covered
Rehabilitation Services	Benefits are based on the setting in which Covered Services are received.	Not covered

Benefits	Indemnity	Out-of-Network
See "Inpatient Services" and "Therapy Services" for details on Benefit Maximums.		
Respiratory Therapy	See "Therapy Services."	Not covered
Skilled Nursing Facility	See "Inpatient Services."	Not covered
Speech Therapy	See "Therapy Services."	Not covered
Surgery <ul style="list-style-type: none"> • Bariatric Surgery Benefit Maximum 	Benefits are based on the setting in which Covered Services are received. Unlimited	Not covered
Telemedicine <ul style="list-style-type: none"> • Primary Care Physician/Provider (PCP) • Specialty Care Physician/Provider (SCP) 		
Temporomandibular and Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Services are received.	Not covered
Therapy Services Benefit Maximum(s): <ul style="list-style-type: none"> • Physical, Occupational, Speech, Chiropractic, Osteopathic Manipulation, Cardiac, Pulmonary Therapy, Pool /Exercise Hydro, Music Therapy, Respiratory & Acupuncture Therapy • Dialysis 	Benefits are based on the setting in which Covered Services are received. Benefit Maximum(s) are for office and outpatient visits combined. 45 visits per Benefit Period Unlimited	Not covered Not covered Not covered Not covered

Benefits	Indemnity	Out-of-Network
<ul style="list-style-type: none"> • Infusion Therapy • Radiation Therapy • Respiratory Therapy 	<p style="text-align: center;">Unlimited</p> <p style="text-align: center;">Unlimited</p> <p style="text-align: center;">Unlimited</p>	<p style="text-align: center;">Not covered</p> <p style="text-align: center;">Not covered</p> <p style="text-align: center;">Not covered</p>
<p>Note: The limits for physical, occupational, and speech therapy will not apply if you get that care as part of the Hospice benefit.</p> <p>Note: When you get physical, occupational, speech therapy, cardiac rehabilitation, or pulmonary rehabilitation in the home, the Home Care Visit limit will apply instead of the Therapy Services limits listed above.</p> <p>Note: If pulmonary rehabilitation is given as part of physical therapy, the Physical Therapy limit will apply instead of the Pulmonary Rehabilitation limit.</p> <p>Note: A separate limit of 45 visits combined telehealth visits for PT/OT/ST ONLY. All other Telehealth therapies (Pool/Exercise Hydro, Acupuncture, Pulmonary Rehab, Cardiac Rehab, Chiropractic, Music Therapy and Osteopathic Manipulations) will apply toward the in-person combined 45 Therapy Visit Limit Maximum.</p> <p>Note: Developmental Delay is covered for PT/OT/ST only.</p>		
<p>Transplant Services</p>	<p style="text-align: center;">See “Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services.”</p>	<p style="text-align: center;">Not covered</p>
<p>Urgent Care Service (Office & Home* Visits)</p>		
<p>Home visits are not the same as Home Health Care. For Home health Care benefits please see the “Home Health Care” section.</p>		
<ul style="list-style-type: none"> • Urgent Care Visit Charge • Allergy Testing • Shots / Injections (other than allergy serum) <p style="margin-left: 20px;">Hyaluronan injections (J7321-J7328) are covered and should bypass medical policy.</p> <ul style="list-style-type: none"> • Allergy Shots / Injections (including allergy serum) • Diagnostic Lab • Diagnostic X-ray • Other Diagnostic Tests (including hearing and EKG) 	<p style="text-align: center;">20% Coinsurance after Deductible</p> <p style="text-align: center;">20% Coinsurance after Deductible</p> <p style="text-align: center;">20% Coinsurance after Deductible</p> <p style="text-align: center;">20% Coinsurance after Deductible</p> <p style="text-align: center;">20% Coinsurance after Deductible</p> <p style="text-align: center;">20% Coinsurance after Deductible</p> <p style="text-align: center;">20% Coinsurance after Deductible</p> <p style="text-align: center;">20% Coinsurance after Deductible</p>	<p style="text-align: center;">Not covered</p> <p style="text-align: center;">Not covered</p> <p style="text-align: center;">Not covered</p> <p style="text-align: center;">Not covered</p> <p style="text-align: center;">Not covered</p> <p style="text-align: center;">Not covered</p> <p style="text-align: center;">Not covered</p>

Benefits	Indemnity	Out-of-Network
<ul style="list-style-type: none"> Advanced Diagnostic Imaging (including MRIs, CAT scans) Office Surgery (including anesthesia) Prescription Drugs Administered in the Office (other than allergy serum) <p>If you get urgent care at a Hospital or other outpatient Facility, please refer to "Outpatient Facility Services" for details on what you will pay.</p>	<p>20% Coinsurance after Deductible</p> <p>20% Coinsurance after Deductible</p> <p>20% Coinsurance after Deductible</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p>
<p>Vision Services (For medical and surgical treatment of injuries and/or diseases of the eye)</p> <p>Certain vision screenings required by Federal law are covered under the "Preventive Care" benefit.</p> <p>If you get Covered Services from an Optometrist, you will not have to pay a Copayment or Coinsurance that is higher than what you would pay for a Primary Care Physician.</p>	<p>Benefits are based on the setting in which Covered Services are received.</p>	<p>Not covered</p>

Human Organ and Tissue Transplant (Bone Marrow / Stem Cell), Cellular and Gene Therapy Services

Please call our Transplant Department as soon as you think you may need a transplant to talk about your benefit options. You must do this *before* you have an evaluation and/or work-up for a transplant. To get the most benefits under your Plan, you must get certain human organ and tissue transplant services from an In-Network Transplant Provider that we have chosen as a Centers of Medical Excellence for Transplant Provider and/or a Provider designated as an In-Network Transplant Provider by the Blue Cross and Blue Shield Association. Even if a Hospital is an In-Network Provider for other services, it may not be an In-Network Transplant Provider for certain transplant services. Please call us to find out which Hospitals are In-Network Transplant Providers. (When calling Member Services, ask for the Transplant Case Manager for further details.)

Centers of Excellence (COE) Transplant Providers

Blue Distinction Center Facility: Blue Distinction facilities have met or exceeded national quality standards for care delivery.

Centers of Medical Excellence (CME): Centers of Medical Excellence facilities have met or exceeded quality standards for care delivery.

In-Network Transplant Provider: Providers who have achieved designation as a Centers of Medical Excellence for Transplant and/or Blue Distinction Centers + or Blue Distinction Centers for Transplant.

Out of Network (PAR) Transplant Provider: Providers participating in the Plan's networks but not designated as a Centers of Medical Excellence for Transplant or Blue Distinction Center + or Blue

Distinction Center for Transplant.

The requirements described below do not apply to the following:

- Cornea transplants, which are covered as any other surgery; and
- Any Covered Services related to a Covered Transplant Procedure that you get before or after the Transplant Benefit Period. Please note that the initial evaluation, any added tests to determine your eligibility as a candidate for a transplant by your Provider, and the collection and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

Benefits for Covered Services that are not part of the Human Organ and Tissue Transplant benefit will be based on the setting in which Covered Services are received. Please see the “What’s Covered” section for additional details.

	In-Network Transplant Provider	In-Network Transplant Provider for this Plan	Out-of-Network Transplant Provider for this Plan
Transplant Benefit Period	Starts one day before a Covered solid organ Transplant Procedure and one day before high dose chemotherapy or preparative regimen for a covered bone marrow/stem cell transplant and lasts for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the In-Network Transplant Provider agreement. Call the Case Manager for specific In-Network Transplant Provider information for services received at or coordinated by an In-Network Transplant Provider Facility.	Starts the day of a Covered Transplant Procedure and continues to the date of discharge at an In-Network Provider Facility.	Starts the day of a Covered Transplant Procedure and continues to the date of discharge at an Out-of-Network Transplant Provider Facility.
Inpatient Facility Services • Precertification required	During the Transplant Benefit Period: 20% Coinsurance after Deductible. Before and after the Transplant Benefit Period, Covered Services will be covered as Inpatient Services, Outpatient Services, Home Visits,	During the Transplant Benefit Period: 20% Coinsurance after Deductible. You will not have to pay for Covered Transplant Procedure charges over the Maximum Allowed Amount.	During the Transplant Benefit Period, You will pay 20% Coinsurance after Deductible. During the Transplant Benefit Period, Covered Transplant Procedure charges at an Out-of-Network Transplant Provider Facility will

	or Office Visits depending where the service is performed.	Prior to and after the Transplant Benefit Period, Covered Services will be covered as Inpatient Services, Outpatient Services, Home Visits, or Office Visits depending where the service is performed.	NOT apply to your Out-of-Pocket Limit. You will have to pay for Covered Transplant Procedure charges over the Maximum Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Services will be covered as Inpatient Services, Outpatient Services, Home Visits, or Office Visits depending where the service is performed.
Inpatient Professional and Ancillary (non-Hospital) Services	20% Coinsurance after Deductible	20% Coinsurance after Deductible	20% Coinsurance after Deductible. These charges will NOT apply to your Out-of-Pocket Limit.
Outpatient Facility Services	20% Coinsurance after Deductible	20% Coinsurance after Deductible	20% Coinsurance after Deductible. These charges will NOT apply to your Out-of-Pocket Limit.
Outpatient Facility Professional and Ancillary (non-Hospital) Services	20% Coinsurance after Deductible	20% Coinsurance after Deductible	20% Coinsurance after Deductible. These charges will NOT apply to your Out-of-Pocket Limit.
Transportation and Lodging	20% Coinsurance after Deductible	20% Coinsurance after Deductible	20% Coinsurance after Deductible. These charges will NOT apply to your Out-of-Pocket Limit.
• Transportation and Lodging Limit	Covered, as approved by the Plan, up to \$10,000 per transplant In-Network Only		20% Coinsurance after Deductible. These charges will NOT apply to your Out-of-Pocket Limit.
Unrelated donor searches from an authorized, licensed registry for bone marrow/stem cell transplants for a	20% Coinsurance after Deductible	20% Coinsurance after Deductible	20% Coinsurance after Deductible. These charges will NOT apply to your Out-of-Pocket Limit.

Covered Transplant Procedure			
• Donor Search Limit	Covered, as approved by the Plan, up to \$30,000 per transplant In- and Out-of-Network combined.		
Live Donor Health Services			
• Inpatient Facility Services	20% Coinsurance after Deductible	20% Coinsurance after Deductible	20% Coinsurance after Deductible. These charges will NOT apply to your Out-of-Pocket Limit.
• Outpatient Facility Services	20% Coinsurance after Deductible	20% Coinsurance after Deductible	20% Coinsurance after Deductible These charges will NOT apply to your Out-of-Pocket Limit.
• Donor Health Service Limit	Medically Necessary charges for getting an organ from a live donor are covered up to the Maximum Allowed Amount, including complications from the donor procedure for up to six weeks from the date of procurement.		

How Your Plan Works

Introduction

Your health Plan is a comprehensive Plan. All Covered Services must be Medically Necessary, and coverage or certification of services that are not Medically Necessary may be denied.

In-Network Provider Services

When you get care from an In-Network Provider or as part of an Authorized Service, benefits are available for Covered Services.

If you receive Covered Services from an Out-of-Network Provider after we failed to provide you with accurate information in our Provider Directory, or after we failed to respond to your telephone or web-based inquiry within the time required by federal law, your cost share for Covered Services will be based on covered at the In-Network level.

Regardless of Medical Necessity, benefits will be denied for care that is not a Covered Service. We have complete authority to decide the Medical Necessity of the service. If you disagree with our determination, you have the right to file an appeal as described in the “Your Right to Appeal” section.

In-Network Providers include Primary Care Physicians / Providers (PCPs), Specialists (Specialty Care Physicians / Providers - SCPs), other professional Providers, Hospitals, and other Facilities who contract with us to care for you. Referrals are never needed to visit an In-Network Specialist, including behavioral health Providers.

To see a Doctor, call their office:

- Tell them you are an Anthem Member.
- Have your Member Identification Card handy. The Doctor’s office may ask you for your group or Member ID number.
- Tell them the reason for your visit.

When you go to the office, be sure to bring your Member Identification Card with you.

In-Network Provider Services

For services from In-Network Providers:

1. You will not need to file claims. In-Network Providers will file claims for Covered Services for you. (You will still need to pay any Coinsurance, Copayments, and/or Deductibles that apply.) You may be billed by your In-Network Provider(s) for any non-Covered Services you get or when you have not followed the terms of this Booklet.
2. Precertification will be done by the In-Network Provider. (See the “Getting Approval for Benefits” section for further details.)

Please read the “Claims Payment” section for additional information on Authorized Services.

After Hours Care

If you need care after normal business hours, your Doctor may have several options for you. You should call your Doctor’s office for instructions if you need care in the evenings, on weekends, or during the

holidays and cannot wait until the office reopens. If you have an Emergency, call 911 or go to the nearest Emergency Room.

Surprise Billing Claims

Surprise Billing Claims are described in the “Consolidated Appropriations Act of 2021 Notice” at the beginning of this Booklet. Please refer to that section for further details.

Connect with Us Using Our Mobile App

As soon as you enroll in this Plan, you should download our mobile app. You can find details on how to do this on our website, www.anthem.com.

Our goal is to make it easy for you to find answers to your questions. You can chat with us live in the app, or contact us on our website, www.anthem.com.

How to Find a Provider in the Network

There are several ways you can find out if a Provider or Facility is in the network for this Plan. You can also find out where they are located and details about their license or training.

- See your Plan’s directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in this Plan’s network.
- Search for a Provider in our mobile app.
- Call Member Services to ask for a list of Doctors and Providers that participate in this Plan’s network, based on specialty and geographic area. Member Services can help you determine the Provider’s name, address, telephone number, professional qualifications, specialty, medical school attended, and board certificates
- Check with your Doctor or Provider.

If you need details about a Provider’s license or training, or help choosing a Doctor who is right for you, call the Member Services number on the back of your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

If an Out-of-Network Provider meets our enrollment criteria and is willing to meet the terms and conditions of our Provider agreement, that Provider has the right to become an In-Network Provider for this Plan. They will not become an In-Network Provider, however, until they have signed the required Provider agreement.

Continuity of Care

If your In-Network Provider leaves our network for any reason other than termination for cause of retirement, death, quality, OR IF COVERAGE UNDER THIS Plan ends because your Group’s Contract ends, or because your Group changes plans, and you are in active treatment, you may be able to continue seeing that Provider for a limited period of time and still get In-Network benefits. “Active treatment” includes:

- 1) An ongoing course of treatment for a life-threatening condition, including a chronic illness or condition. A chronic illness or condition is a condition that is life-threatening, degenerative, potentially disabling, or congenital and requires specialized medical care over a prolonged period of time,
- 2) An ongoing course of treatment for a serious acute condition (e.g., chemotherapy, radiation therapy and post-operative visits),
- 3) An ongoing course of treatment for pregnancy and through the postpartum period, or

- 4) A scheduled non-elective surgery from the Provider, including receipt of postoperative care from such Provider or Facility with respect to such a surgery; or
- 5) An ongoing course of treatment for a health condition for which the Physician or health care Provider attests that discontinuing care by the current Physician or Provider would worsen your condition or interfere with anticipated outcomes, or
- 6) Continuing care benefits for members undergoing a course of institutional or Inpatient care from the Provider or Facility and/or determined to be terminally ill and is receiving treatment for such illness from such Provider or Facility.

An “ongoing course of treatment” includes treatments for Mental Health and Substance Use Disorders.

If you wish to continue seeing the same Provider, you or your Doctor should contact Member Services for details. Any decision by us regarding a request for Continuity of Care is subject to the process described in “Complaint and Appeals Process.” Continuity of care under this section will end the earlier of completion of treatment, 90 days after the effective date of termination or non-renewal, nine months if you have been diagnosed with a terminal illness at the time of termination, or in the case of pregnancy, six weeks following delivery.

Your Cost-Shares

Your Plan may involve Copayments, Deductibles, and/or Coinsurance, which are charges that you must pay when receiving Covered Services. Your Plan may also have an Out-of-Pocket Limit, which limits the cost-shares you must pay. Please read the “Schedule of Benefits” for details on your cost-shares. Also read the “Definitions” section for a better understanding of each type of cost share.

Crediting Prior Plan Coverage

If you were covered by the Employer’s prior carrier / plan immediately before the Employer signs up with us, with no break in coverage, then you will get credit for any accrued Deductible and, if applicable and approved by us, Out of Pocket amounts under that other plan. This does not apply to people who were not covered by the prior carrier or plan on the day before the Employer’s coverage with us began, or to people who join the Employer later.

If your Employer moves from one of our plans to another, (for example, changes its coverage from HMO to PPO), and you were covered by the other product immediately before enrolling in this product with no break in coverage, then you may get credit for any accrued Deductible and Out of Pocket amounts, if applicable and approved by us. Any maximums, when applicable, will be carried over and charged against the maximums under this Plan.

If your Employer offers more than one of our products, and you change from one product to another with no break in coverage, you will get credit for any accrued Deductible and, if applicable, Out of Pocket amounts and any maximums will be carried over and charged against maximums under this Plan.

If your Employer offers coverage through other products or carriers in addition to ours, and you change products or carriers to enroll in this product with no break in coverage, you will get credit for any accrued Deductible, Out of Pocket, and any maximums under this Plan.

For the Deductible, the credit applies for the same or overlapping benefit periods and will be given for costs you paid toward the deductible of the Employer’s prior carrier or plan in the 90 days before the Employer’s effective date with us. You will also receive credit for any satisfaction or partial satisfaction of waiting periods under the Employer’s prior carrier or plan.

This Section Does Not Apply To You If:

- Your Employer moves to this Plan at the beginning of a Benefit Period;
- You change from one of our individual policies to a group plan;
- You change employers; or
- You are a new Member who joins the Employer after the Employer's initial enrollment with us.

The BlueCard Program

Like all Blue Cross & Blue Shield plans throughout the country, we participate in a program called "BlueCard," which provides services to you when you are outside our Service Area. For more details on this program, please see "Inter-Plan Arrangements" in the "Claims Payment" section.

Identification Card

We will give an Identification Card to each Member enrolled in the Plan. When you get care, you must show your Identification Card. Only covered Members have the right to services or benefits under this Booklet. If anyone gets services or benefits to which they are not entitled to under the terms of this Booklet, he/she must pay for the actual cost of the services.

Getting Approval for Benefits

Your Plan includes the process of Utilization Review to decide when services are Medically Necessary or Experimental/Investigational as those terms are defined in this Booklet. Utilization Review aids the delivery of cost-effective health care by reviewing the use of treatments and, when proper, level of care and/or the setting or place of service that they are performed.

Reviewing Where Services Are Provided

A service must be Medically Necessary to be a Covered Service. When level of care, setting or place of service is reviewed, services that can be safely given to you in a lower level of care/setting/place of care will not be Medically Necessary if they are given in a higher level of care/setting/place of care. This means that a request for a service may be denied because it is not Medically Necessary for the service to be provided where it is being requested. When this happens the service can be requested again in another place and will be reviewed again for Medical Necessity. At times a different Provider or Facility may need to be used in order for the service to be considered Medically Necessary. Examples include:

- A service may be denied on an inpatient basis at a Hospital but may be approvable if provided on an outpatient basis at a Hospital.
- A service may be denied on an outpatient basis at a Hospital but may be approvable at a free standing imaging center, infusion center, Ambulatory Surgery Center, or in a Physician's office.
- A service may be denied at a Skilled Nursing Facility but may be approvable in a home setting.

Utilization Review criteria will be based on many sources including medical policy and clinical guidelines. Anthem, on behalf of the Employer, may decide that a service that was asked for is not Medically Necessary if you have not tried other clinically equivalent treatments that are more cost effective and appropriate. "Clinically equivalent" means treatments that for most Members, will give you similar results for a disease or condition.

If you have any questions about the Utilization Review process, the medical policies, or clinical guidelines, you may call the Member Services phone number on the back of your Identification Card.

Coverage for or payment of the service or treatment reviewed is not guaranteed even if it is decided that your services are Medically Necessary. For benefits to be covered, on the date you get service:

1. You must be eligible for benefits;
2. Fees must be paid for the time period that services are given;
3. The service or supply must be a Covered Service under your Plan;
4. The service cannot be subject to an Exclusion under your Plan; and
5. You must not have exceeded any applicable limits under your Plan.

Types of Reviews

- **Pre-service Review** – A review of a service, treatment or admission for a benefit coverage determination, which is done before the service or treatment begins or admission date.

Precertification – A required Pre-service Review for a benefit coverage determination for a service or treatment. Certain services require Precertification in order for you to get benefits. The benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity or is Experimental / Investigational as those terms are defined in this Booklet.

For admissions following Emergency Care, you, your authorized representative or Doctor must tell us within 24 hours of the admission or as soon as possible within a reasonable period of time. For

childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time. Precertification is not required for the first 48 hours for a vaginal delivery or 96 hours for a cesarean section. Admissions longer than 48/96 hours require precertification.

- **Continued Stay / Concurrent Review** - A Utilization Review of a service, treatment or admission for a benefit coverage determination which must be done during an ongoing stay in a facility or course of treatment.

Both Pre-Service and Continued Stay / Concurrent Reviews may be considered urgent when, in the view of the treating Provider or any Doctor with knowledge of your medical condition, without such care or treatment, your life or health or your ability to regain maximum function could be seriously threatened or you could be subjected to severe pain that cannot be adequately managed without such care or treatment. Urgent reviews are conducted under a shorter timeframe than standard reviews.

- **Post-service Review** – A review of a service, treatment or admission for a benefit coverage determination that is conducted after the service has been provided. Post-service reviews are performed when a service, treatment or admission did not need a Precertification, or when a needed Precertification was not obtained. Post-service reviews are done for a service, treatment or admission in which we have a related clinical coverage guideline and are typically initiated by us.

Who is Responsible for Precertification?

Typically, In-Network Providers know which services need Precertification and will get any Precertification when needed. Your Primary Care Physician and other In-Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Doctor (“requesting Provider”) will get in touch with us to ask for a Precertification. However, you may request a Precertification or you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older. The table below outlines who is responsible for Precertification and under what circumstances.

Provider Network Status	Responsibility to Get Precertification	Comments
In Network	Provider	The Provider must get Precertification when required
Out of Network/ Non-Participating	Member	<p>Member has no benefit coverage for an Out-of-Network Provider unless:</p> <ul style="list-style-type: none"> • The Member gets approval to use an Out-of-Network Provider before the service is given, or. • The Member requires an Emergency Care admission. (See note below.) <p>If these are true, then</p> <ul style="list-style-type: none"> • The Member must get Precertification when required. (Call Member Services.) For an Emergency Care admission, precertification is not required. However, you, your authorized representative, or Doctor must tell us within 24

Provider Network Status	Responsibility to Get Precertification	Comments
		<p>hours of the admission or as soon as possible within a reasonable period of time.</p> <ul style="list-style-type: none"> Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found to not be Medically Necessary, not Emergency Care, or any charges in excess of the Maximum Allowed Amount.
BlueCard Provider	Member (Except for Inpatient Admissions)	<p>Member has no benefit coverage for a BlueCard Provider unless:</p> <ul style="list-style-type: none"> The Member gets approval to use a BlueCard Provider before the service is given, or. The Member requires an Emergency Care admission. (See note below.) <p>If these are true, then</p> <ul style="list-style-type: none"> The Member must get Precertification when required. (Call Member Services.) For an Emergency Care admission, precertification is not required. However, you, your authorized representative, or Doctor must tell us within 24 hours of the admission or as soon as possible within a reasonable period of time. Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found to not be Medically Necessary, not Emergency Care, or any charges in excess of the Maximum Allowed Amount. BlueCard Providers must obtain precertification for all Inpatient Admissions.
<p>NOTE: For an Emergency Care admission, precertification is not required. However, you, your authorized representative or Doctor must tell us within 24 hours of the admission or as soon as possible within a reasonable period of time.</p>		

How Decisions are Made

We use our clinical coverage guidelines, such as medical policy, clinical guidelines, and other applicable policies and procedures to help make our Medical Necessity decisions. This includes decisions about Prescription Drugs as detailed in the section "Prescription Drugs Administered by a Medical Provider." Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. We reserve the right, on behalf of the Employer, to review and update these clinical coverage guidelines from time to time.

You are entitled to ask for and get, free of charge, reasonable access to any records concerning your request. To ask for this information, call the Precertification phone number on the back of your Identification Card.

If you are not satisfied with the decision under this section of your benefits, please refer to the “Your Right to Appeal” section to see what rights may be available to you.

Decision and Notice Requirements

We will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on federal laws. If you live in and/or get services in a state other than the state where your Contract was issued other state-specific requirements may apply. You may call the phone number on the back of your Identification Card for more details.

Request Category	Timeframe Requirement for Decision and Notification
Urgent Pre-Service Review	24 hours from the receipt of all necessary information
Non-Urgent Pre-Service Review	5 calendar days from the receipt of all necessary information
Urgent Continued Stay / Concurrent Review when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of all necessary information
Urgent Continued Stay / Concurrent Review when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	24 hours from the receipt of all necessary information
Non-Urgent Continued Review for ongoing outpatient treatment	5 calendar days from the receipt of all necessary information
Post-Service Review	5 calendar days from the receipt of all necessary information

If more information is needed to make our decision, we will tell the requesting Provider of the specific information needed to finish the review. If we do not get the specific information we need or if the information is not complete by the required timeframe, we will make a decision based upon the information we have.

We will notify you and your Provider of the decision as required by state and federal law. Notice may be given by one or more of the following methods: verbal, written, and/or electronic.

Important Information

On behalf of the Employer, Anthem may, from time to time, waive, enhance, change or end certain medical management processes (including utilization management, case management, and disease management) and/or offer an alternate benefit if in our discretion, such change furthers the provision of cost effective, value based and/or quality services.

We may also select certain qualifying Providers to take part in a program or a Provider arrangement that exempts them from certain procedural or medical management processes that would otherwise apply. We may also exempt your claim from medical review if certain conditions apply.

Just because Anthem exempts a process, Provider or Claim from the standards which otherwise would apply, it does not mean that Anthem will do so in the future, or will do so in the future for any other Provider, claim or Member. Anthem may stop or change any such exemption with or without advance notice.

You may find out whether a Provider is taking part in certain programs or a Provider arrangement by contacting the Member Services number on the back of your ID card.

Health Plan Individual Case Management

Our health plan individual case management programs (Case Management) help coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the Case Management program to help meet their health-related needs.

Our Case Management programs are confidential and voluntary and are made available at no extra cost to you. These programs are provided by, or on behalf of and at the request of, your health plan case management staff. These Case Management programs are separate from any Covered Services you are receiving.

If you meet program criteria and agree to take part, we will help you meet your identified health care needs. This is reached through contact and teamwork with you and/or your chosen authorized representative, treating Doctor(s), and other Providers.

In addition, we may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, the Plan may provide benefits for alternate care that is not listed as a Covered Service. The Plan may also extend Covered Services beyond the Benefit Maximums of this Plan. We will make any recommendation for alternate or extended benefits to the Plan on a case-by-case basis, if in our discretion the alternate or extended benefit is in the best interest of you and the Plan and you or your authorized representative agree to the alternate or extended benefit in writing. A decision to provide extended benefits or approve alternate care in one case does not obligate the Plan to provide the same benefits again to you or to any other Member. The Plan reserves the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, we will notify you or your authorized representative in writing.

What's Covered

This section describes the Covered Services available under your Plan. Covered Services are subject to all the terms and conditions listed in this Booklet, including, but not limited to, Benefit Maximums, Deductibles, Copayments, Coinsurance, Exclusions and Medical Necessity requirements. Please read the "Schedule of Benefits" for details on the amounts you must pay for Covered Services and for details on any Benefit Maximums. Also be sure to read "How Your Plan Works" for more information on your Plan's rules. Read the "What's Not Covered" section for important details on Excluded Services.

Your benefits are described below. Benefits are listed alphabetically to make them easy to find. Please note that several sections may apply to your claims. For example, if you have inpatient surgery, benefits for your Hospital stay will be described under "Inpatient Hospital Care" and benefits for your Doctor's services will be described under "Inpatient Professional Services." As a result, you should read all sections that might apply to your claims.

You should also know that many Covered Services can be received in several settings, including a Doctor's office or your home, an Urgent Care Facility, an Outpatient Facility, or an Inpatient Facility. **For services to be covered, they must be provided in the lowest level of care that is medically appropriate.** The costs of services will often vary depending on the setting and from whom you choose to get Covered Services, and the choice of setting can result in a change in the amount you need to pay or even in a denial for the services. Please see the "Schedule of Benefits" and the "Getting Approval for Benefits" sections for more details.

Please note that care must be received from your Primary Care Physician (PCP) or another In-Network Provider to be a Covered Service under this Plan. If you use an Out-of-Network Provider, your entire claim will be denied unless:

- The services are for Emergency Care; or
- The services are approved in advance by Anthem as an Authorized Service.

Allergy Services

Your Plan includes benefits for Medically Necessary allergy testing and treatment, including allergy serum and allergy shots.

Ambulance Services

Medically Necessary ambulance services are a Covered Service when:

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation.

And one or more of the following criteria are met:

- For ground ambulance, you are taken:
 - From your home, the scene of an accident or medical Emergency to a Hospital;
 - Between Hospitals, including when we require you to move from an Out-of-Network Hospital to an In-Network Hospital
 - Between a Hospital and a Skilled Nursing Facility or other approved Facility.
- For air or water ambulance, you are taken:
 - From the scene of an accident or medical Emergency to a Hospital;

- Between Hospitals, including when we require you to move from an Out-of-Network Hospital to an In-Network Hospital
- Between a Hospital and an approved Facility.

Ambulance services are subject to Medical Necessity reviews by us. Emergency ground ambulance services do not require precertification and are allowed regardless of whether the Provider is an In-Network or Out-of-Network Provider. For Emergency ambulance services performed by an Out-of-Network Provider you do not need to pay any more than would have been paid for services from an In-Network Provider.

Non-Emergency ambulance services are subject to Medical Necessity reviews by us. When using an air ambulance for non-Emergency transportation, we reserve the right to select the air ambulance Provider. If you do not use the air ambulance Provider we select, no benefits will be available. Please see the "Schedule of Benefits" for the maximum benefit.

You must be taken to the nearest Facility that can give care for your condition. In certain cases we may approve benefits for transportation to a Facility that is not the nearest Facility.

Benefits also include Medically Necessary treatment of a sickness or injury by medical professionals from an ambulance service, even if you are not taken to a Facility.

Ambulance services are not covered when another type of transportation can be used without endangering your health. Ambulance services for your convenience or the convenience of your family or Doctor are not a Covered Service.

Other non-covered ambulance services include trips to:

- A Doctor's office or clinic;
- A morgue or funeral home.

Important Notes on Air Ambulance Benefits

Benefits are only available for air ambulance when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger your health and your medical condition requires a more rapid transport to a Facility than the ground ambulance can provide, the Plan will cover the air ambulance. Air ambulance will also be covered if you are in an area that a ground or water ambulance cannot reach.

Air ambulance will not be covered if you are taken to a Hospital that is not an acute care Hospital (such as a Skilled Nursing Facility or a rehabilitation facility), or if you are taken to a Physician's office or your home.

Hospital to Hospital Transport

If you are moving from one Hospital to another, air ambulance will only be covered if using a ground ambulance would endanger your health and if the Hospital that first treats cannot give you the medical services you need. Certain specialized services are not available at all Hospitals. For example, burn care, cardiac care, trauma care, and critical care are only available at certain Hospitals. To be covered, you must be taken to the closest Hospital that can treat you. **Coverage is not available for air ambulance transfers simply because you, your family, or your Provider prefers a specific Hospital or Physician.**

Behavioral Health Services

Please see "Mental Health and Substance Use Disorder Services" later in this section.

Biomarker Testing Services

This Plan provides coverage for biomarker testing when ordered by a Qualified Health Care Provider's scope of practice for the purpose of diagnosis, treatment, appropriate management, or ongoing monitoring of a Member's disease or condition when the test is supported by medical and scientific evidence, including but not limited to:

- a) Labeled indications from an FDA-approved or cleared test;
- b) Indicated tests for an FDA-approved Drug;
- c) Warnings and precautions on FDA-approved Drug labels;
- d) Centers for Medicare and Medicaid Services national coverage determinations;
- e) Medicare Administrative Contractor local coverage determinations;
- f) Nationally recognized clinical practice guidelines; or
- g) Consensus statements.

Breast Cancer Treatment

This Plan covers services to treat breast cancer including chemotherapy, high-dose chemotherapy with autologous bone marrow transplants or stem cell transplants, mastectomies, prosthetics, and reconstructive services needed after the mastectomy. Please see the rest of the Booklet for details on how each benefit is covered.

Cardiac Rehabilitation

Please see "Therapy Services" later in this section.

Cellular and Gene Therapy Services

Your Plan includes benefits for certain cellular and gene therapy services, when Anthem approves the benefits in advance through Precertification. See the section "Human Organ and Tissue Transplant (Bone Marrow / Stem Cell), Cellular and Gene Therapy Services" for additional details.

Chemotherapy

Please see "Therapy Services" later in this section.

Chiropractor Services

Please see "Therapy Services" later in this section.

Clinical Trials

Benefits include coverage for services, such as routine patient care costs, given to you as a participant in an approved clinical trial if the services are Covered Services under this Plan. An "approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
 - a. The National Institutes of Health.
 - b. The Centers for Disease Control and Prevention.
 - c. The Agency for Health Care Research and Quality.
 - d. The Centers for Medicare & Medicaid Services.
 - e. Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
 - f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
 - g. Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
 - i. The Department of Veterans Affairs.
 - ii. The Department of Defense.
 - iii. The Department of Energy.
2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;
3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Your Plan may require you to use an In-Network Provider to maximize your benefits.

Routine patient care costs include items, services, and drugs provided to you in connection with an approved clinical trial that would otherwise be covered by this Plan.

All requests for clinical trials services, including services that are not part of approved clinical trials will be reviewed according to our Clinical Coverage Guidelines, related policies and procedures.

Your Plan is not required to provide benefits for the following services. We reserve our right to exclude any of the following services:

- i. The Investigational item, device, or service; or
- ii. Items and services that are given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
- iii. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
- iv. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Congenital Defects and Birth Abnormalities

Covered Services include the treatment of medically-diagnosed congenital defects and birth abnormalities.

Dental Services

Preparing the Mouth for Medical Treatments

Your Plan includes coverage for dental services to prepare the mouth for medical services and treatments such as radiation therapy to treat cancer and prepare for transplants. Covered Services include:

- Evaluation
- Dental x-rays
- Extractions, including surgical extractions
- Anesthesia

Treatment of Accidental Injury

Benefits are also available for dental work needed to treat injuries to the jaw, sound natural teeth, mouth or face as a result of an accident. An injury that results from chewing or biting is not considered an Accidental Injury under this Plan, unless the chewing or biting results from a medical or mental condition.

Other Dental Services

The Plan will also cover Hospital or Ambulatory Surgery Center charges and anesthesia for dental care if the Member is:

1. Under the age of 20,
2. Has a serious mental or physical condition; or
3. Has significant behavioral problems.

The Member's Provider must certify that hospitalization or general anesthesia is required to safely and effectively give the dental care. Benefits do not include routine dental care or treatment of dental conditions not covered by the Plan.

Diabetes Equipment, Education, and Supplies

Benefits are available for medical services, supplies, equipment, insulin, and Prescription Drugs needed to treat diabetes. Covered Services also include diabetic self-management training and education programs, including medical nutrition therapy.

Diagnostic Services

Your Plan includes benefits for tests or procedures to find or check a condition when specific symptoms exist. Tests must be ordered by a Provider and include diagnostic services ordered before a surgery or Hospital admission. Benefits include the following services:

Diagnostic Laboratory and Pathology Services

- Laboratory and pathology tests, such as blood tests.
- Genetic tests, when allowed by us. Certain genetic tests for cancer are covered under the "Preventive Care" benefit. Please see that section for details.
- Chromosomal Microarray Analysis (CMA) for Developmental Delay, Autism Spectrum Disorder, Intellectual Disability (Intellectual Developmental Disorder) and Congenital Anomalies.

Diagnostic Imaging Services and Electronic Diagnostic Tests

- X-rays / regular imaging services
- Ultrasound

- Electrocardiograms (EKG)
- Electroencephalography (EEG)
- Echocardiograms
- Hearing and vision tests for a medical condition or injury (not for screenings or preventive care)
- Tests ordered before a surgery or admission.

Advanced Imaging Services

Benefits are also available for advanced imaging services, which include but are not limited to:

- CT scan
- CTA scan
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Magnetic resonance spectroscopy (MRS)
- Nuclear Cardiology
- PET scans
- PET/CT Fusion scans
- QCT Bone Densitometry
- Diagnostic CT Colonography

The list of advanced imaging services may change as medical technologies change.

Dialysis

Please see “Therapy Services“ later in this section.

Durable Medical Equipment (DME), Medical Devices, and Supplies

Durable Medical Equipment and Medical Devices

Your Plan includes benefits for durable medical equipment and medical devices when the equipment meets the following criteria:

- Is meant for repeated use and is not disposable.
- Is used for a medical purpose and is of no further use when medical need ends.
- Is meant for use outside a medical Facility.
- Is only for the use of the patient.
- Is made to serve a medical use.
- Is ordered by a Provider.

Benefits include purchase-only equipment and devices (e.g., crutches and customized equipment), purchase or rent-to-purchase equipment and devices (e.g., Hospital beds and wheelchairs), and continuous rental equipment and devices (e.g., oxygen concentrator, ventilator, and negative pressure wound therapy devices). Continuous rental equipment must be approved by us. We may limit the amount of coverage for ongoing rental of equipment. We may not cover more in rental costs than the cost of simply purchasing the equipment.

Benefits include repair and replacement costs as well as supplies and equipment needed for the use of the equipment or device, for example, a battery for a powered wheelchair.

Oxygen and equipment for its administration are also Covered Services.

Orthotics

Benefits are available for certain types of orthotics (braces, boots, splints). Covered Services include the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part.

Orthotics may only be replaced once per year, when Medically Necessary. However, additional replacements will be allowed:

- For Members when needed as a result of rapid growth, or
- For Members of any age, when an appliance is damaged and cannot be repaired.

Prosthetics

Your Plan also includes benefits for prosthetics, which are artificial substitutes for body parts for functional or therapeutic purposes, when they are Medically Necessary for activities of daily living.

Benefits include the purchase, fitting, adjustments, repairs and replacements. Covered Services may include, but are not limited to:

- 1) Artificial limbs and accessories.
- 2) One pair of glasses or contact lenses used after surgical removal of the lens(es) of the eyes.
- 3) Breast prosthesis (whether internal or external) and surgical bras (6 per Benefit period) after a mastectomy, as required by the Women's Health and Cancer Rights Act.
- 4) Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
- 5) Restoration prosthesis (composite facial prosthesis).
- 6) Wigs needed after cancer treatment.
- 7) Cochlear implants.
- 8) Hearing aids and related services for Members under age 18. Benefits include Medically Necessary hearing aids, including bone-anchored hearing aids, for Members under age 18. Benefits also include services to assess, select, adjust or fit the hearing aid. You can get Covered Services from a licensed audiologist or a licensed hearing instrument specialist.

Medical and Surgical Supplies

Your Plan includes coverage for medical and surgical supplies that serve only a medical purpose, are used once, and are purchased (not rented). Covered supplies include syringes, needles, surgical dressings, splints, and other similar items that serve only a medical purpose. Covered Services do not include items often stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

Blood and Blood Products

Your Plan also includes coverage for the administration of blood products.

Emergency Care Services

If you are experiencing an Emergency please call 911 or visit the nearest Hospital for treatment.

Emergency Services

Benefits are available in a Hospital Emergency Room or freestanding Emergency Facility for services and supplies to treat the onset of symptoms for an Emergency, which is defined below.

Emergency (Emergency Medical Condition)

“Emergency,” or “Emergency Medical Condition” means a medical or behavioral health condition of recent onset and sufficient severity, including but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that not getting immediate medical care could result in: (a) placing the patient’s health or the health of another person in serious danger or, for a pregnant women, placing the women’s health or the health of her unborn child in serious danger; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. Such conditions include but are not limited to, chest pain, stroke, poisoning, serious breathing problems, unconsciousness, severe burns or cuts, uncontrolled bleeding, or seizures and such other acute conditions as may be determined to be Emergencies by us.

Emergency Care

“Emergency Care” means a medical or behavioral health exam done in the Emergency Department of a Hospital or freestanding Emergency Facility, and includes services routinely available in the Emergency Department to evaluate an Emergency Condition. It includes any further medical or behavioral health exams and treatment required to stabilize the patient. Emergency Care may also include necessary services, including observation services, provided as part of the Emergency visit regardless of the department in which the services are provided

Medically Necessary services will be covered whether you get care from an In-Network or Out-of-Network Provider. Emergency Care you get from an Out-of-Network Provider will be covered as an In-Network service and will not require Precertification. The Out-of-Network Provider can only charge you any applicable Deductible, Coinsurance, and/or Copayment and cannot bill you for the difference between the Maximum Allowed Amount and their billed charges until your condition is stable as described in the “Consolidated Appropriations Act of 2021 Notice” at the front of this Booklet. Your cost shares will be based on the Maximum Allowed Amount, and will be applied to your In-Network Deductible and In-Network Out-of-Pocket Limit. For Surprise Billing Claims, the Out-of-Network Provider can only charge you any applicable Deductible, Coinsurance, and/or Copayment and cannot bill you for the difference between the Maximum Allowed Amount and their billed charges until your condition is stable and the Out of Network Provider has complied with the notice and consent process as described in the “Consolidated Appropriations Act of 2021 Notice” at the front of this Booklet. Your cost shares will be based on the Recognized Amount, and will be applied to your In-Network Deductible and In-Network Out-of-Pocket Limit.

The Maximum Allowed Amount for Emergency Care from an Out-of-Network Provider will be determined using the median Plan In-Network contract rate we pay In-Network Providers for the geographic area where the service is provided for same or similar services.

If you are admitted to the Hospital from the Emergency Room, be sure that you or your Doctor calls us as soon as you are stabilized. We will review your care to decide if a Hospital stay is needed and how many days you should stay. See “Getting Approval for Benefits” for more details.

Treatment you get after your condition has stabilized is not Emergency Care. Please refer to the “Consolidated Appropriations Act of 2021 Notice” at the front of this Booklet for more details on how this will impact your benefits.

Gender Affirming Services

This Plan provides benefits for gender affirming services, including gender affirming surgery and hormone, for Members diagnosed with Gender Dysphoria. To be eligible for benefits, services must be Medically Necessary and all inpatient Facility admissions must be approved in advance through Precertification. Please refer to the “Getting Approval for Benefits” section for further details.

Details on our medical policies are also available online at www.anthem.com/provider/policies/clinical-guidelines.

Services Not Eligible for Coverage

Your Plan does not include benefits for the following:

- i. Services determined to be Experimental / Investigational;
- ii. Services provided by a non-approved Provider or at a non-approved Facility; or
- iii. Services not approved in advance through Precertification.

Habilitative Services

Benefits also include habilitative health care services and devices that help you keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Please see “Therapy Services” later in this section for further details.

Hinge Health

Through the Hinge Health Digital Musculoskeletal (MSK) Clinic, participants have access to personalized MSK care programs depending on their specific MSK needs. Participants will register online through the Hinge Health website or app, complete a clinically validated screener to determine which program best fits their MSK needs. The programs include:

- (a) Prevention - Program designed to increase education with regards to key strengthening and stretching activities around healthy habits. The Prevention program is software based and offered through the Hinge Health app.
- (b) Chronic - Program designed to address long term back and joint pain which includes personalized exercise therapy sessions guided by wearable sensors, 1:1 access to a personalized health coach, personalized education content, and behavioral health support. Participants in the chronic program may also be offered access to virtual sessions with a licensed Physical Therapist and/or the non-invasive ENSO High Frequency Impulse Therapy™ pain management device and service, as appropriate, for symptomatic relief.
- (c) Acute - Program designed to address recent injuries which includes live virtual sessions with a dedicated licensed Physical Therapist along with software guided rehabilitation and education.
- (d) Surgery - Program designed to address pre/post surgery rehab for the most common MSK Surgeries which includes personalized exercise therapy sessions guided by wearable sensors, 1:1 access to a personalized health coach and physical therapist, personalized education content, and behavioral health support.

To be eligible for the Hinge Health programs, You, and Your eligible dependents must meet each of the following requirements: (i.) be enrolled in an Anthem medical plan, (ii.) be age 18 or older (iii) be

located in the United States, and (iv.) be approved through the clinical suitability evaluation performed by Hinge Health prior to enrollment.

If You are eligible, Hinge Health is offered at no cost to You.

Contact information to get started with Hinge Health, visit hingehealth.com/inspirebrands to enroll. If You have any questions regarding Hinge Health, email help@hingehealth.com or call (855)902-2777.

Home Health Care Services

Benefits are available for Covered Services performed by a Home Health Care Agency or other Home Health Care Provider in your home. To be eligible for benefits, you must essentially be confined to the home, as an alternative to a Hospital stay, and be physically unable to get needed medical services on an outpatient basis. Services must be prescribed by a Doctor and the services must be so inherently complex that they can be safely and effectively performed only by qualified, technical, or professional health staff.

Covered Services include but are not limited to:

- Intermittent skilled nursing services by an R.N. or L.P.N.
- Medical / social services
- Diagnostic services
- Nutritional guidance
- Training of the patient and/or family/caregiver
- Home health aide services. You must be receiving skilled nursing or therapy. Services must be given by appropriately trained staff working for the Home Health Care Provider. Other organizations may give services only when approved by us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider or other Provider as approved by us.
- Therapy Services (except for Manipulation Therapy which will not be covered when given in the home)
- Medical supplies
- Durable medical equipment

Benefits may also be available for Inpatient Services in your home. These benefits are separate from the Home Health Care Services benefit, and are described in the “Inpatient Services” section below.

Home Infusion Therapy

Please see “Therapy Services” later in this section.

Hospice Care

You are eligible for hospice care if your Doctor and the Hospice medical director certify that you are terminally ill and likely have less than twelve (12) months to live. You may access hospice care while participating in a clinical trial or continuing disease modifying therapy, as ordered by your treating Provider. Disease modifying therapy treats the underlying terminal illness.

The services and supplies listed below are Covered Services when given by a Hospice for the palliative care of pain and other symptoms that are part of a terminal disease. Palliative care means care that controls pain and relieves symptoms, but is not meant to cure a terminal illness. Covered Services include:

- Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term Inpatient Hospital care when needed in periods of crisis or as respite care.
- Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse.
- Social services and counseling services from a licensed social worker.
- Nutritional support such as intravenous feeding and feeding tubes.
- Physical therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist.
- Pharmaceuticals, medical equipment, and supplies needed for the palliative care of your condition, including oxygen and related respiratory therapy supplies.
- Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Member's death. Bereavement services are available to the patient and those individuals who are closely linked to the patient, including the immediate family, the primary or designated caregiver and individuals with significant personal ties, for one year after the Member's death.

Your Doctor must agree to care by the Hospice and must be consulted in the development of the care plan. The Hospice must keep a written care plan on file and give it to us upon request.

Benefits for services beyond those listed above that are given for disease modification or palliation, such as chemotherapy and radiation therapy, are available to a Member in Hospice. These services are covered under other parts of this Plan.

Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Cellular and Gene Therapy Services

Your Plan includes coverage for Medically Necessary human organ and tissue transplants. Certain transplants (e.g., cornea) are covered like any other surgery, under the regular inpatient and outpatient benefits described elsewhere in this Booklet.

This section describes benefits for certain Covered Transplant Procedures that you get during the Transplant Benefit Period. Any Covered Services related to a Covered Transplant Procedure, received before or after the Transplant Benefit Period, are covered under the regular Inpatient and outpatient benefits described elsewhere in this Booklet.

Please call our Transplant Department as soon as you think you may need a transplant to talk about your benefit options. You must do this *before* you have an evaluation and/or work-up for a transplant. To get the most benefits under your Plan, you must get certain human organ and tissue transplant services from an In-Network Transplant Provider that we have chosen as a Centers of Medical Excellence for Transplant Provider and/or a Provider designated as an In-Network Transplant Provider by the Blue Cross and Blue Shield Association. Even if a Hospital is an In-Network Provider for other services, it may not be an In-Network Transplant Provider for certain transplant services. Please call us to find out which Hospitals are In-Network Transplant Providers. (When calling Member Services, ask for the Transplant Case Manager for further details.)

In this section you will see some key terms, which are defined below:

Covered Transplant Procedure

As decided by us, any Medically Necessary human solid organ, tissue, and stem cell / bone marrow transplants and infusions including necessary acquisition procedures, mobilization, collection and storage. It also includes Medically Necessary myeloablative or reduced intensity preparative chemotherapy, radiation therapy, or a combination of these therapies.

Centers of Excellence (COE) Transplant Providers

- **Blue Distinction Center (BDC) Facility:** Blue Distinction facilities have met or exceeded national quality standards for transplant care delivery.
- **Centers of Medical Excellence (CME) Facility:** Centers of Medical Excellence facilities have met or exceeded quality standards for transplant care delivery.

In-Network Transplant Provider

A Provider that we have chosen and designated as a Centers of Medical Excellence for Transplant and/or Blue Distinction Centers + or Blue Distinction Centers for Transplant. The Provider has entered into a Transplant Provider Agreement to give Covered Transplant Procedures to you and take care of certain administrative duties for the transplant network. A Provider may be an In-Network Transplant Provider for:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

Out-of-Network Transplant Provider

Any Provider that has **NOT** been chosen as a Center of Medical Excellence for Transplant by us or has not been selected to take part as an In-Network Transplant Provider by the Blue Cross and Blue Shield Association.

Transplant Benefit Period

At an In-Network Transplant Provider Facility, the Transplant Benefit Period starts one day before a Covered solid organ Transplant Procedure and one day before high dose chemotherapy or preparative regimen for a covered bone marrow/stem cell transplant procedure and lasts for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the In-Network Transplant Provider agreement. Call the Case Manager for specific In-Network Transplant Provider details for services received at or coordinated by an In-Network Transplant Provider Facility.

Prior Approval and Precertification

To maximize your benefits, you should call our Transplant Department as soon as you think you may need a transplant to talk about your benefit options. You must do this before you have an evaluation and/or work-up for a transplant. We will help you maximize your benefits by giving you coverage information, including details on what is covered and if any clinical coverage guidelines, medical policies, In-Network Transplant Provider rules, or Exclusions apply. Call the Member Services phone number on the back of your Identification Card and ask for the transplant coordinator. Even if we give a prior approval for the Covered Transplant Procedure, you or your Provider must call our Transplant Department for Precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

Precertification is required before the Plan will cover benefits for a transplant. Your Doctor must certify, and we must agree, that the transplant is Medically Necessary. Your Doctor should send a written request for Precertification to us as soon as possible to start this process. Not getting Precertification will result in a denial of benefits.

Please note that there are cases where your Provider asks for approval for Human Leukocyte Antigen (HLA) testing, donor searches and/or a collection and storage of stem cells prior to the final decision as to what transplant procedure will be needed. In these cases, the HLA testing and donor search charges will be covered as routine diagnostic tests. The collection and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or

collection and storage is NOT an approval for the later transplant. A separate Medical Necessity decision will be needed for the transplant.

Transportation and Lodging

The Plan will cover the cost of reasonable and necessary travel costs when you get prior approval and need to travel more than 75 miles from your permanent home to reach the Facility where the Covered Transplant Procedure will be performed. Help with travel costs includes transportation to and from the Facility, and lodging for the patient and one companion. If the Member receiving care is a minor, then reasonable and necessary costs for transportation and lodging may be allowed for two companions. You must send itemized receipts for transportation and lodging costs in a form satisfactory to us when claims are filed. Call us for complete information.

For lodging and ground transportation benefits, the Plan will cover costs up to the current limits set forth in the Internal Revenue Code.

Non-Covered Services for transportation and lodging include:

- Child care,
- Mileage within the medical transplant Facility city,
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by us,
- Frequent Flyer miles,
- Coupons, Vouchers, or Travel tickets,
- Prepayments or deposits,
- Services for a condition that is not directly related, or a direct result, of the transplant,
- Phone calls,
- Laundry,
- Postage,
- Entertainment,
- Travel costs for donor companion/caregiver,
- Return visits for the donor for a treatment of an illness found during the evaluation,
- Meals.

Infertility Services

Please see “Maternity and Reproductive Health Services” later in this section.

Inpatient Services

Inpatient Hospital Care

Covered Services include acute care in a Hospital setting Hospital in Home arrangement:

Benefits for room, board, and nursing services include:

- A room with two or more beds.
- A private room. The most the Plan will cover for private rooms is the Hospital’s average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.

- A room in a special care unit approved by us. The unit must have facilities, equipment, and supportive services for intensive care or critically ill patients.
- Routine nursery care for newborns during the mother's normal Hospital stay.
- Meals, special diets.
- General nursing services.

Benefits for ancillary services include:

- Operating, childbirth, and treatment rooms and equipment.
- Prescribed Drugs.
- Anesthesia, anesthesia supplies and services given by the Hospital or other Provider.
- Medical and surgical dressings and supplies, casts, and splints.
- Diagnostic services.
- Therapy services.

Inpatient Professional Services

Covered Services include:

- Medical care visits.
- Intensive medical care when your condition requires it.
- Treatment for a health problem by a Doctor who is not your surgeon while you are in the Hospital for surgery. Benefits include treatment by two or more Doctors during one Hospital stay when the nature or severity of your health problem calls for the skill of separate Doctors.
- A personal bedside exam by another Doctor when asked for by your Doctor. Benefits are not available for staff consultations required by the Hospital, consultations asked for by the patient, routine consultations, phone consultations, or EKG transmittals by phone.
- Surgery and general anesthesia.
- Newborn exam. A Doctor other than the one who delivered the child must do the exam.
- Newborn diet. Covered Services include a 100% human diet to supplement the mother's expressed breast milk or donor milk with a milk fortifier if the diet is:
 1. Prescribed for the prevention of Necrotizing Enterocolitis and associated comorbidities; and
 2. Administered under the direction of a physician.

"100% human diet" means supplementing the mother's expressed breast milk or donor milk with a milk fortifier. "Milk fortifier" means a commercially prepared human milk fortifier made from concentrated 100% human milk.

- Professional charges to interpret diagnostic tests such as imaging, pathology reports, and cardiology.

*When available in your area, certain Providers have programs available that may allow you to receive Inpatient Services in your home instead of staying in a Hospital. To be eligible, your condition and the Covered Services to be delivered must be appropriate for the home setting. Your home must also meet certain accessibility requirements. These programs are voluntary and are separate from the benefits under "Home Health Care Services." Your Provider will contact you if you are eligible, and provide you with details on how to enroll. If you choose to participate, the cost-shares listed in your Schedule of Benefits under "Inpatient Services" will apply.

Maternity and Reproductive Health Services

Maternity Services

Covered Services include services needed during a normal or complicated pregnancy and for services needed for a miscarriage. Covered maternity services include:

- Professional and Facility services for childbirth in a Facility or the home including the services of an appropriately licensed nurse midwife;
- Routine nursery care for the newborn during the mother's normal Hospital stay, including circumcision of a covered male Dependent;
- Prenatal, postnatal, and postpartum services; and
- Fetal screenings, which are genetic or chromosomal tests of the fetus, as allowed by us.

If you are pregnant on your Effective Date and in the first trimester of the pregnancy, you must change to an In-Network Provider to have Covered Services covered at the In-Network level. If you are pregnant on your Effective Date and in your second or third trimester of pregnancy (13 weeks or later) as of the Effective Date, benefits for obstetrical care will be available at the In-Network level even if an Out-of-Network Provider is used if you fill out a Continuation of Care Request Form and send it to us. Covered Services will include the obstetrical care given by that Provider through the end of the pregnancy and the immediate post-partum period.

Important Note About Maternity Admissions: Under federal law, the Plan may not limit benefits for any Hospital length of stay for childbirth for the mother or newborn to less than 48 hours after vaginal birth, or less than 96 hours after a cesarean section (C-section). However, federal law as a rule does not stop the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours, or 96 hours, as applicable. In any case, as provided by federal law, the Plan may not require a Provider to get authorization from us before prescribing a length of stay which is not more than 48 hours for a vaginal birth or 96 hours after a C-section.

Endometriosis and Endometritis

Your Plan also covers the diagnosis and treatment of endometriosis and endometritis.

Contraceptive Benefits

Benefits include contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants. Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for further details.

Sterilization Services

Benefits include sterilization services and services to reverse a non-elective sterilization that resulted from an illness or injury. Reversals of elective sterilizations are not covered. Sterilizations for women are covered under the "Preventive Care" benefit.

Abortion Services

Benefits are limited to abortions performed to preserve the life of the female upon whom the abortion is performed. Elective abortions are not a Covered Service.

Infertility Services

Important Note: Although this Plan offers limited coverage of certain infertility services, it does not cover all forms of infertility treatment. Benefits do not include assisted reproductive technologies (ART) or the diagnostic tests and Drugs to support it. Examples of ART include artificial insemination, in-vitro fertilization, zygote intrafallopian transfer (ZIFT), or gamete intrafallopian transfer (GIFT).

Covered Services include diagnostic tests to find the cause of infertility, such as diagnostic laparoscopy, endometrial biopsy, and semen analysis. Benefits also include services to treat the underlying medical conditions that cause infertility (e.g., endometriosis, obstructed fallopian tubes, and hormone deficiency). Fertility treatments such as artificial insemination and in-vitro fertilization are not a Covered Service.

Mental Health and Substance Use Disorder Services

Covered Services include the following:

- **ABA Therapy** - Medically Necessary applied behavioral analysis services.
- **Inpatient Services** in a Hospital or any Facility that we must cover per state law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification.
- **Residential Treatment** in a licensed Residential Treatment Center that offers individualized and intensive treatment and includes:
 - Observation and assessment by a physician weekly or more often,
 - Rehabilitation and therapy.
- **Outpatient Services** including office visits, therapy and treatment, Partial Hospitalization/Day Treatment Programs, and Intensive Outpatient Programs
- **Virtual Visits** as described under the “Virtual Visits and Telehealth Services” section.

Examples of Providers from whom you can receive Covered Services include:

- Psychiatrist,
- Psychologist,
- Neuropsychologist,
- Licensed clinical social worker (L.C.S.W.),
- Mental health clinical nurse specialist,
- Licensed marriage and family therapist (L.M.F.T.),
- Licensed professional counselor (L.P.C) or
- Any agency licensed by the state to give these services, when we have to cover them by law.

Occupational Therapy

Please see “Therapy Services” later in this section.

Office and Home Visits

Covered Services include:

Office Visits for medical care (including second opinions) to examine, diagnose, and treat an illness or injury.

Consultations between your Primary Care Physician and a Specialist, when approved by Anthem.

Home Visits for medical care to examine, diagnose, and treat an illness or injury. Please note that Doctor and Primary Care Provider visits in the home are different than the “Home Health Care Services” benefit described earlier in this Booklet.

Retail Health Clinic Care for limited basic health care services to Members on a “walk-in” basis. These clinics are normally found in major pharmacies or retail stores. Health care services are typically given by Physician’s Assistants or Nurse Practitioners. Services are limited to routine care and treatment of common illnesses for adults and children.

Walk-In Doctor's Office for services limited to routine care and treatment of common illnesses for adults and children. You do not have to be an existing patient or have an appointment to use a walk-in Doctor's office.

Urgent Care as described in "Urgent Care Services" later in this section.

Virtual Visits as described under the "Virtual Visits and Telehealth Services" section.

Prescription Drugs Administered in the Office

Orthotics

Please see "Durable Medical Equipment (DME), Medical Devices, and Supplies" earlier in this section.

Outpatient Facility Services

Your Plan includes Covered Services in an:

- Outpatient Hospital,
- Freestanding Ambulatory Surgery Center,
- Mental Health / Substance Use Disorder Facility, or
- Other Facilities approved by us.

Benefits include Facility and related (ancillary) charges, when proper, such as:

- Surgical rooms and equipment,
- Prescription Drugs, including Specialty Drugs,
- Anesthesia and anesthesia supplies and services given by the Hospital or other Facility,
- Medical and surgical dressings and supplies, casts, and splints,
- Diagnostic services,
- Therapy services.

Physical Therapy

Please see "Therapy Services" later in this section.

Preventive Care

Preventive care includes screenings and other services for adults and children. All recommended preventive services will be covered as required by the Affordable Care Act (ACA) and applicable state law. This means many preventive care services are covered with no Deductible, Copayments, or Coinsurance when you use an In-Network Provider.

Certain benefits for Members who have current symptoms or a diagnosed health problem may be covered under the "Diagnostic Services" benefit instead of this benefit, if the coverage does not fall within the state or ACA-recommended preventive services.

Covered Services fall under the following broad groups:

1. Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples include screenings for:
 - a. Breast cancer,

- b. Cervical cancer,
 - c. Colorectal cancer –This includes the preventive colonoscopy, anesthesia, polyp removal, and pathology tests in connection with the preventive screening. It also includes a preventive screening following a positive non-invasive stool-based screening test or following a positive direct visualization test (i.e. flexible sigmoidoscopy, CT colonography),
 - d. High blood pressure,
 - e. Type 2 Diabetes Mellitus,
 - f. Cholesterol,
 - g. Child and adult obesity.
2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
 3. Preventive care and screenings for infants, children and adolescents as listed in the guidelines supported by the Health Resources and Services Administration;
 4. Preventive care and screening for women as listed in the guidelines supported by the Health Resources and Services Administration, including:
 - a. Women’s contraceptives, sterilization treatments, and counseling. Coverage includes contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants. Contraceptives covered on the pharmacy benefit will either have a \$0 copay for generics or a copay depending on formulary status and medication classification (generic, brand, multi-source brand). For details on what contraceptives are covered on the pharmacy benefit and what the cost would be, contact the UK Pharmacy Benefit office at 859-218-5979.
 - b. Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per year.
 - c. Gestational diabetes screening.
 5. Preventive care services for smoking cessation and tobacco cessation for Members age 18 and older as recommended by the United States Preventive Services Task Force including counseling.
 6. Prescription Drugs and OTC items identified as an A or B recommendation by the United States Preventive Services Task Force when prescribed by a Provider including:
 - a. Aspirin
 - b. Folic acid supplement
 - c. Bowel preparations
 - d. FDA-approved preexposure prophylaxis (PrEP), related services and monitoring including follow up HIV testing and additional testing to monitor the effects of the PrEP medications.

Please note that certain age and gender and quantity limitations apply.

You may call Member Services at the number on your Identification Card for more details about these services or view the federal government’s websites, <https://www.healthcare.gov/what-are-my-preventive-care-benefits>, <http://www.ahrq.gov>, and <http://www.cdc.gov/vaccines/acip/index.html>.

Covered Services also include these services:

- Routine bone density testing for women.
- Routine colorectal cancer exams and related lab tests as specified in the most recent version of the American Cancer Society guidelines.

- Routine screening mammograms. Breast examination including, but not limited to, screening mammograms, diagnostic mammography, breast magnetic resonance imaging (MRI), or breast ultrasound
- Annual pap smears for women.
- Genetic tests for cancer risk if recommended by the most recent guidelines published by the National Comprehensive Cancer Network (NCCN).

Preventive Care for Chronic Conditions (per IRS guidelines)

Members with certain chronic health conditions may be able to receive preventive care for those conditions prior to meeting their Deductible when services are provided by an In-Network Provider. These benefits are available if the care qualifies under guidelines provided by the Treasury Department, Internal Revenue Service (IRS), and Department of Health and Human Services (HHS) (referred to as “the agencies”).

<https://www.irs.gov/newsroom/irs-expands-list-of-preventive-care-for-hsa-participants-to-include-certain-care-for-chronic-conditions>

Preventive Care for Specified Conditions	For Individuals Diagnosed with
Angiotensin Converting Enzyme (ACE) inhibitors	Congestive heart failure, diabetes, and/or coronary artery disease
Anti-resorptive therapy	Osteoporosis and/or osteopenia
Beta-blockers	Congestive heart failure and/or coronary artery disease
Blood pressure monitor	Hypertension
Inhaled corticosteroids	Asthma
Insulin and other glucose lowering agents	Diabetes
Retinopathy screening	Diabetes
Peak flow meter	Asthma
Glucometer	Diabetes
Hemoglobin A1c testing	Diabetes
International Normalized Ratio (INR) testing	Liver disease and/or bleeding disorders
Low-density Lipoprotein (LDL) testing	Heart disease
Selective Serotonin Reuptake Inhibitors (SSRIs)	Depression
Statins	Heart disease and/or diabetes

The agencies will periodically review the list of preventive care services and items to determine whether additional services or items should be added or if any should be removed from the list. You will be notified if updates are incorporated into your Plan.

Please refer to the Schedule of Benefits for further details on how benefits will be paid.

Prosthetics

Please see “Durable Medical Equipment (DME), Medical Devices, and Supplies” earlier in this section.

Pulmonary Therapy

Please see “Therapy Services” later in this section.

Radiation Therapy

Please see “Therapy Services” later in this section.

Rehabilitation Services

Benefits include services in a Hospital, free-standing Facility, Skilled Nursing Facility, or in an outpatient day rehabilitation program.

Covered Services involve a coordinated team approach and several types of treatment, including skilled nursing care, physical, occupational, and speech therapy, and services of a social worker or psychologist.

To be Covered Services, rehabilitation services must involve goals you can reach in a reasonable period of time. Benefits will end when treatment is no longer Medically Necessary and you stop progressing toward those goals.

Please see “Therapy Services” in this section for further details.

Respiratory Therapy

Please see “Therapy Services” later in this section.

Skilled Nursing Facility

When you require Inpatient skilled nursing and related services for convalescent and rehabilitative care, Covered Services are available if the Facility is licensed or certified under state law as a Skilled Nursing Facility. Custodial Care is not a Covered Service.

Smoking Cessation

Please see the “Preventive Care” section in this Booklet.

Speech Therapy

Please see “Therapy Services” later in this section.

Surgery

Your Plan covers surgical services on an Inpatient or outpatient basis, including office surgeries. Covered Services include:

- Accepted operative and cutting procedures;
- Other invasive procedures, such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine;
- Endoscopic exams, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy;
- Treatment of fractures and dislocations;
- Anesthesia and surgical support when Medically Necessary;

- Medically Necessary pre-operative and post-operative care.

Oral Surgery

Important Note: Although this Plan covers certain oral surgeries, many oral surgeries are not covered.

Benefits are limited to certain oral surgeries including:

- Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia;
- Orthognathic surgery for a physical abnormality that prevents normal function of the upper and/or lower jaw and is Medically Necessary to attain functional capacity of the affected part.
- Oral / surgical correction of accidental injuries as indicated in the “Dental Services (All Members / All Ages)” section.
- Treatment of non-dental lesions, such as removal of tumors and biopsies.
- Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.
- Removal of impacted wisdom teeth.

This Plan does not cover extraction of teeth and other oral surgeries to treat the teeth or bones and gums directly supporting the teeth.

Reconstructive Surgery

Benefits include reconstructive surgery to correct significant deformities caused by congenital or developmental abnormalities, illness, injury or an earlier treatment in order to create a more normal appearance. Benefits include surgery performed to restore symmetry after a mastectomy.

Note: This section does not apply to orthognathic surgery. See the “Oral Surgery” section above for that benefit.

Mastectomy Notice

A Member who is getting benefits for a mastectomy or for follow-up care for a mastectomy and who chooses breast reconstruction, will also get coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to give a symmetrical appearance; and
- Prostheses and treatment of physical problems of all stages of mastectomy, including lymphedemas.

Members will have to pay the same Deductible, Coinsurance, and/or Copayments that normally apply to surgeries in this Plan.

Bariatric Surgery

Benefits include coverage for any Medically Necessary bariatric surgery procedure.

Telemedicine

Covered Services that are appropriately provided by a Telemedicine Provider will be eligible for benefits under this Plan when allowed by us. Telemedicine means the mode of delivering health care or other health services via information and communication technologies to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a patient’s physical and mental health. In-person contact between a health care Provider and the patient is not required for these services, and the type of setting where these are services are provided is not limited. Telemedicine does

not include the use of facsimile, texting or electronic mail. If you have any questions about this coverage, or receive a bill please contact Member Services at the number on the back of your Identification Card.

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

Benefits are available to treat temporomandibular and craniomandibular disorders. The temporomandibular joint connects the lower jaw to the temporal bone at the side of the head and the craniomandibular joint involves the head and neck muscles.

Covered Services include removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services. Covered Services do not include fixed or removable appliances that involve movement or repositioning of the teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures).

Therapy Services

Physical Medicine Therapy Services

Your Plan includes coverage for the therapy services described below. To be a Covered Service, the therapy must improve your level of function within a reasonable period of time. Covered Services include:

- **Physical therapy** – The treatment by physical means to ease pain, restore health, and to avoid disability after an illness, injury, or loss of an arm or a leg. It includes hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles and devices.
- **Speech therapy and speech-language pathology (SLP) services** – Services to identify, assess, and treat speech, language, and swallowing disorders in children and adults. Therapy will develop or treat communication or swallowing skills to correct a speech impairment.
- **Post-cochlear implant aural therapy** – Services to help a person understand the new sounds they hear after getting a cochlear implant.
- **Occupational therapy** – Treatment to restore a physically disabled person's ability to do activities of daily living, such as walking, eating, drinking, dressing, using the toilet, moving from a wheelchair to a bed, and bathing. It also includes therapy for tasks needed for the person's job. Occupational therapy does not include recreational or vocational therapies, such as hobbies, arts and crafts.
- **Chiropractic / Osteopathic / Manipulation therapy** – Includes therapy to treat problems of the bones, joints, and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy also focuses on the joints and surrounding muscles, tendons and ligaments.

Other Therapy Services

Benefits are also available for:

- **Cardiac Rehabilitation** – Medical evaluation, training, supervised exercise, and psychosocial support to care for you after a cardiac event (heart problem). Benefits do not include home programs, on-going conditioning, or maintenance care.
- **Chemotherapy** – Treatment of an illness by chemical or biological antineoplastic agents. See the section "Prescription Drugs Administered by a Medical Provider" for more details.
- **Dialysis** – Services for acute renal failure and chronic (end-stage) renal disease, including hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). Covered Services include dialysis treatments in an outpatient dialysis Facility. Covered Services also include home dialysis and training for you and the person who will help you with home self-dialysis.
- **Infusion Therapy** – Nursing, durable medical equipment and Drug services that are delivered and administered to you through an I.V. in your home. Also includes Total Parenteral Nutrition (TPN),

Enteral nutrition therapy, antibiotic therapy, pain care and chemotherapy. May include injections (intra-muscular, subcutaneous, continuous subcutaneous). See the section “Prescription Drugs Administered by a Medical Provider” for more details.

- **Pulmonary Rehabilitation** – Includes outpatient short-term respiratory care to restore your health after an illness or injury.
- **Cognitive rehabilitation therapy** – Medically Necessary cognitive rehabilitation, including therapy following a post-traumatic brain injury or cerebral vascular accident.
- **Radiation Therapy** – Treatment of an illness by x-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies needed, and treatment planning.
- **Respiratory Therapy** – Includes the use of dry or moist gases in the lungs, nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.

Transplant Services

Please see “Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services” earlier in this section.

Urgent Care Services

Often an urgent rather than an Emergency health problem exists. An urgent health problem is an unexpected illness or injury that calls for care that cannot wait until a regularly scheduled office visit. Urgent health problems are not life threatening and do not call for the use of an Emergency Room. Urgent health problems include earache, sore throat, and fever (not above 104 degrees).

Benefits for urgent care include:

- X-ray services;
- Care for broken bones;
- Tests such as flu, urinalysis, pregnancy test, rapid strep;
- Lab services;
- Stitches for simple cuts; and
- Draining an abscess.

Virtual Visits and Telehealth Services

Covered Services include virtual Telehealth visits that are appropriately provided through the internet via video or telephone chat or voice. This includes visits with Providers who also provide services in person, as well as virtual care-only Providers.

- “Telehealth” means the delivery of health care or other health services using electronic communications and information technology, including: live (synchronous) secure videoconferencing or secure instant messaging through our mobile app; interactive store and forward (asynchronous) technology; or remote patient monitoring technology. Covered Services are provided to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a patient’s physical and/or mental health. In-person contact between a health care Provider and the patient is not required for these services, and the type of setting where these services are provided is not limited.

“Remote patient monitoring” means the delivery of home health services using telecommunications

technology to enhance the delivery of home health care, including monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and other condition-specific data; medication adherence monitoring; and interactive video conferencing with or without digital image upload.

Please Note: Not all services can be delivered through virtual visits. Certain services require equipment and/or direct physical hands-on care that cannot be provided remotely. Also, please note that not all Providers offer virtual visits.

Benefits do not include the use of facsimile, texting (outside of our mobile app), electronic mail, or non-secure instant messaging. Benefits also do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to Providers outside our network, or benefit precertification.

If you have any questions about this coverage, please contact Member Services at the number on the back of your Identification Card.

Vision Services

Benefits include medical and surgical treatment of injuries and illnesses of the eye. Certain vision screenings required by Federal law are covered under the "Preventive Care" benefit.

Benefits do not include glasses or contact lenses. However, one pair of glasses or contact lenses is covered after surgical removal of the lens(es) of the eyes under the "Prosthetics" benefit.

Prescription Drugs Administered by a Medical Provider

Your Plan covers Prescription Drugs, including Specialty Drugs that must be administered to you as part of a doctor's visit, home care visit, or at an outpatient Facility when they are Covered Services. This may include Drugs for infusion therapy, chemotherapy, blood products, certain injectables, and any Drug that must be administered by a Provider. This section applies when a Provider orders the Drug and a medical Provider administers it to you in a medical setting.

Prescription Drugs you get from a Retail or Mail Order Pharmacy are not covered by this Plan.

Covered Prescription Drugs

To be a Covered Service, Prescription Drugs must be approved by the Food and Drug Administration (FDA) and, under federal law, require a Prescription. Prescription Drugs must be prescribed by a licensed Provider and Controlled Substances must be prescribed by a licensed Provider with an active DEA license.

Compound ingredients within a compound drug are a Covered Service when a commercially available dosage form of a Medically Necessary medication is not available, ingredients of the compound drug are FDA approved, require a prescription to dispense, and are not essentially the same as an FDA approved product from a drug manufacturer. Non-FDA approved, non-proprietary, multisource ingredients that are vehicles essential for compound administration may be covered.

Precertification

Precertification may be required for certain Prescription Drugs to help make sure proper use and guidelines for Prescription Drug coverage are followed. We will give the results of the decision to both you and your Provider.

For a list of Prescription Drugs that need precertification, please call the phone number on the back of your Express Scripts Identification Card. The list will be reviewed and updated from time to time. Including a Prescription Drug or related item on the list does not guarantee coverage under your Plan. Your Provider may check with us to verify Prescription Drug coverage, to find out which drugs are covered under this section and if any drug edits apply.

Please refer to the section "Getting Approval for Benefits" for more details.

If precertification is denied you have the right to file an appeal as outlined in the "Your Right to Appeal" section of this Booklet.

Designated Pharmacy Provider

Anthem, on behalf of the Employer, in its discretion, may establish one or more Designated Pharmacy Provider programs which provide specific pharmacy services (including shipment of Prescription Drugs) to Members. An In-Network Provider is not necessarily a Designated Pharmacy Provider. To be a Designated Pharmacy Provider, the In-Network Provider must have signed a Designated Pharmacy Provider Agreement with Anthem. You or your Provider can contact Member Services to learn which Pharmacy or Pharmacies are part of a Designated Pharmacy Provider program.

For Prescription Drugs that are shipped to you or your Provider and administered in your Provider's office, you and your Provider are required to order from a Designated Pharmacy Provider. A Patient Care coordinator will work with you and your Provider to obtain Precertification and to assist shipment to your Provider's office.

The Plan may also require you to use a Designated Pharmacy Provider to obtain Prescription Drugs for treatment of certain clinical conditions such as Hemophilia. We reserve our right to modify the list of Prescription Drugs as well as the setting and/or level of care in which the care is provided to you. Express Scripts may, from time to time, change upon advance notice, the Designated Pharmacy Provider for a Drug, if in our discretion, such change can help provide cost effective, value based and/or quality services.

If you are required to use a Designated Pharmacy Provider and you choose not to obtain your Prescription Drug from a Designated Pharmacy Provider, you will not have coverage for that Prescription Drug.

You can get the list of the Prescription Drugs covered under this section by calling Member Services at the phone number on the back of your Express Scripts Identification Card or check our website at <https://www.express-scripts.com>.

Therapeutic Substitution

Therapeutic equivalents is a program that tells you and your Doctor about alternatives to certain prescribed Drugs. We may contact you and your Doctor to make you aware of these choices. Only you and your Doctor can determine if the therapeutic equivalent is right for you. For questions or issues about therapeutic Drug equivalents call Member Services at the phone number on the back of your Identification Card.

What's Not Covered

In this section you will find a review of items that are not covered by your Plan. Excluded items will not be covered even if the service, supply, or equipment is Medically Necessary. This section is only meant to be an aid to point out certain items that may be misunderstood as Covered Services. This section is not meant to be a complete list of all the items that are excluded by your Plan.

- 1) **Abortion** Services, supplies, Prescription Drugs, and other care for elective (voluntary) abortions and/or fetal reduction surgery.

This Exclusion does not apply to abortions performed to preserve the life of the female upon whom the abortion is performed.
- 2) **Administrative Charges**
 - a) Charges to complete claim forms,
 - b) Charges to get medical records or reports,
 - c) Membership, administrative, or access fees charged by Doctors or other Providers. Examples include fees for educational brochures or calling you to give you test results.
- 3) **Aids for Non-verbal Communication** Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices approved by Anthem.
- 4) **Alternative / Complementary Medicine** Services or supplies for alternative or complementary medicine. This includes:
 - a. Acupressure, or massage to help alleviate pain, treat illness or promote health by putting pressure to one or more areas of the body.
 - b. Premenstrual Syndrome Clinic/Holistic medicine,
 - c. Homeopathic medicine,
 - d. Hypnosis,
 - e. Aroma therapy,
 - f. Massage and massage therapy, except for massage therapy services that are part of a physical therapy treatment plan and covered under the "Therapy Services" section of this Booklet,
 - g. Reiki therapy,
 - h. Herbal, vitamin or dietary products or therapies,
 - i. Naturopathy,
 - j. Thermography,
 - k. Orthomolecular therapy,
 - l. Contact reflex analysis,
 - m. Bioenergetic synchronization technique (BEST),
 - n. Iridology-study of the iris,
 - o. Auditory integration therapy (AIT),
 - p. Colonic irrigation,
 - q. Magnetic innervation therapy,
 - r. Electromagnetic therapy,
 - s. Biofeedback.
- 5) **Autopsies** Autopsies and post-mortem testing.
- 6) **Before Effective Date or After Termination Date** Charges for care you get before your Effective Date or after your coverage ends, except as written in this Plan.

- 7) **Certain Providers** Services you get from Providers that are not licensed by law to provide Covered Services as defined in this Booklet. Examples include masseurs or masseuses (massage therapists), physical therapist technicians, and athletic trainers, Telehealth providers not licensed in Kentucky and not participating in an interstate medical compact.
- 8) **Charges Not Supported by Medical Records** Charges for services not described in your medical records.
- 9) **Charges Over the Maximum Allowed Amount** Charges over the Maximum Allowed Amount for Covered Services except for Surprise Billing Claims as outlined in the “Consolidated Appropriations Act of 2021 Notice” in the front of this Booklet.
- 10) **Chats or Texts** Chats and texting are not a Covered Service unless appropriately provided via a secure and compliant application, according to applicable legal requirements
- 11) **Christian Science Practitioner Services.**
- 12) **Clinical Trial Non-Covered Services** Any Investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a Covered Service under this Plan for non-Investigational treatments.
- 13) **Clinically-Equivalent Alternatives** Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless required by law. “Clinically equivalent” means Drugs that for most Members, will give you similar results for a disease or condition. If you have questions about whether a certain Drug is covered and which Drugs fall into this group, please call the number on the back of your Identification Card, or contact KYRx at 859-218-5979.

If you or your Doctor believes you need to use a different Prescription Drug, please have your Doctor or pharmacist get in touch with us. The Plan will cover the other Prescription Drug only if we, on behalf of the Employer, agree that it is Medically Necessary and appropriate over the clinically equivalent Drug. We will review benefits for the Prescription Drug from time to time to make sure the Drug is still Medically Necessary.

- 14) **Complications of/or Services Related to Non-Covered Services** Services, supplies, or treatment related to or, for problems directly related to a service that is not covered by this Plan. Directly related means that the care took place as a direct result of the non-Covered Service and would not have taken place without the non-Covered Service.
- 15) **Compound Drugs** Compound ingredients that are not FDA approved or do not require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.
- 16) **Cosmetic Services** Treatments, services, Prescription Drugs, equipment, or supplies given for cosmetic services. Cosmetic services are meant to preserve, change, or improve how you look or are given for social reasons. No benefits are available for surgery or treatments to change the texture or look of your skin or to change the size, shape or look of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts).

This Exclusion does not apply to reconstructive surgery for breast symmetry after a mastectomy or to surgery to correct congenital defects and birth abnormalities.
- 17) **Court Ordered Testing** Court ordered testing or care unless Medically Necessary.
- 18) **Crime** Treatment of an injury or illness that results from a crime you committed, or tried to commit. This Exclusion does not apply if your involvement in the crime was solely the result of a medical or mental condition, or where you were the victim of a crime, including domestic violence. This Exclusion also does not apply unless the Member is incarcerated in a local penal institution or in the custody of a local law enforcement officer as a result of a conviction for a felony.
- 19) **Cryopreservation** Charges associated with the cryopreservation of eggs, embryos, or sperm, including collection, storage, and thawing.

- 20) **Custodial Care** Custodial Care, convalescent care or rest cures. This Exclusion does not apply to Hospice services.
- 21) **Delivery Charges** Charges for delivery of Prescription Drugs.
- 22) **Dental Devices for Snoring** Oral appliances for snoring.
- 23) **Dental Treatment** Dental treatment, except as listed below.
- Excluded treatment includes preventive care and fluoride treatments; dental X-rays, supplies, appliances and all associated costs; and diagnosis and treatment for the teeth, jaw or gums such as:
- Removing, restoring, or replacing teeth;
 - Medical care or surgery for dental problems (unless listed as a Covered Service in this Booklet);
 - Services to help dental clinical outcomes.
- Dental treatment for injuries that are a result of biting or chewing is also excluded, unless the chewing or biting results from a medical or mental condition.
- This Exclusion does not apply to services that we must cover by law.
- 24) **Drugs Contrary to Approved Medical and Professional Standards** Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
- 25) **Drugs Over Quantity or Age Limits** Drugs which are over any quantity or age limits set by the Plan or us.
- 26) **Drugs Over the Quantity Prescribed or Refills After One Year** Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
- 27) **Drugs Prescribed by Providers Lacking Qualifications / Registrations / Certifications** Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations, and/or certifications, as determined by Anthem.
- 28) **Drugs That Do Not Need a Prescription** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin or other Drugs provided in the Preventive Care paragraph of the “What’s Covered” section.
- 29) **Educational Services** Services, supplies or room and board for teaching, vocational, or self-training purposes. This includes boarding schools and/or the room and board and educational components of a residential program where the primary focus of the program is educational in nature rather than treatment based.
- 30) **Experimental or Investigational Services** Services or supplies that are found to be Experimental / Investigational. This also applies to services related to Experimental / Investigational services, whether you get them before, during, or after you get the Experimental / Investigational service or supply.
- The fact that a service or supply is the only available treatment will not make it Covered Service if we conclude it is Experimental / Investigational. Please see “Additional Information about Experimental / Investigational Services” at the end of this section for more details.
- 31) **Eyeglasses and Contact Lenses** Eyeglasses and contact lenses to correct your eyesight unless listed as covered in this Booklet. This Exclusion does not apply to lenses needed after a covered eye surgery.
- 32) **Eye Exercises** Orthoptics and vision therapy.
- 33) **Eye Surgery** Eye surgery to fix errors of refraction, such as near-sightedness. This includes LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy.
- 34) **Family Members** Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.

- 35) **Foot Care** Routine foot care unless Medically Necessary. This Exclusion applies to cutting or removing corns and calluses; trimming nails; cleaning and preventive foot care, including:
- a) Cleaning and soaking the feet.
 - b) Applying skin creams to care for skin tone.
 - c) Other services that are given when there is not an illness, injury or symptom involving the foot.
- 36) **Foot Orthotics** Foot orthotics, orthopedic shoes or footwear or support items unless used for a systemic illness affecting the lower limbs, such as severe diabetes.
- 37) **Fraud, Waste, Abuse, and Other Inappropriate Billing** Services from an Out-of-Network Provider that are determined to be not payable as a result of fraud, waste, abuse or inappropriate billing activities. This includes an Out-of-Network Provider's failure to submit medical records required to determine the appropriateness of a claim.
- 38) **Free Care** Services you would not have to pay for if you didn't have this Plan. This includes government programs, services during a jail or prison sentence, services you get from Workers Compensation, and services from free clinics.
- If your Employer is not required to have Workers Compensation coverage, this Exclusion does not apply. This Exclusion will apply if you get the benefits in whole or in part. This Exclusion also applies whether or not you claim the benefits or compensation, and whether or not you get payments from any third party.
- This Exclusion does not apply to a Member incarcerated in a local penal institution or in the custody of a local law enforcement officer prior to conviction for a felony.
- 39) **Growth Hormone Treatment** Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.
- 40) **Health Club Memberships and Fitness Services** Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, even if ordered by a Doctor. This Exclusion also applies to health spas.
- 41) **Hearing Aids** Hearing aids, including bone-anchored hearing aids, or exams to prescribe or fit hearing aids, including bone-anchored hearing aids, unless listed as covered in this Booklet. This Exclusion does not apply to hearing aids for children under age 18. It also does not apply to cochlear implants.
- 42) **Home Health Care**
- a) Services given by registered nurses and other health workers who are not employees of or working under an approved arrangement with a Home Health Care Provider.
 - b) Private Duty Nursing.
 - c) Food, housing, homemaker services and home delivered meals.
- 43) **Hospital Services Billed Separately** Services rendered by Hospital resident Doctors or interns that are billed separately. This includes separately billed charges for services rendered by employees of Hospitals, labs or other institutions, and charges included in other duplicate billings.
- 44) **Hyperhidrosis Treatment** Medical and surgical treatment of excessive sweating (hyperhidrosis).
- 45) **Infertility Treatment** Infertility procedures not specified in the "Infertility Services" section.
- 46) **Lost or Stolen Drugs** Refills of lost or stolen Drugs.
- 47) **Maintenance Therapy** Rehabilitative treatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function, but does not result in any change for the better.

- 48) **Medical Chats Not Provided through our Mobile App** Texting or chat services provided through a service other than our mobile app.
- 49) **Medical Equipment, Devices, and Supplies**
- a) Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
 - b) Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
 - c) Non-Medically Necessary enhancements to standard equipment and devices.
 - d) Supplies, equipment and appliances, including hearing aids and wigs, that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in your situation. Reimbursement will be based on the Maximum Allowed Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense, including items you purchase with features that exceed what is Medically Necessary, will be limited to the Maximum Allowed Amount for the standard items, and the additional costs will be your responsibility.
 - e) Disposable supplies for use in the home such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances or devices that are not specifically listed as covered in the "What's Covered" section.
- 50) **Medicare** For which benefits are payable under Medicare Parts A and/or B, or would have been payable if you had applied for Parts A and/or B, except as listed in this Booklet or as required by federal law, as described in the section titled "Medicare" in "General Provisions." If you do not enroll in Medicare Part B when you are eligible, you may have large out-of-pocket costs. Please refer to [Medicare.gov](#) for more details on when you should enroll.
- 51) **Missed or Cancelled Appointments** Charges for missed or cancelled appointments.
- 52) **Non-approved Drugs** Drugs not approved by the FDA.
- 53) **Non-Approved Facility** Services from a Provider that does not meet the definition of Facility.
- 54) **Non-Medically Necessary Services** Services we conclude are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.
- 55) **Nutritional or Dietary Supplements** Nutritional and/or dietary supplements, except as described in this Booklet or that must be covered by law. This Exclusion includes nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written Prescription or from a licensed pharmacist.
- 56) **Off label use** Off label use unless we approve it.
- 57) **Out-of-Network Care** Services from a Provider that is not in our network. This does not apply to Emergency Care or Authorized Services.
- 58) **Oral Surgery** Extraction of teeth and other oral surgeries to treat the teeth or bones and gums directly supporting the teeth, except as listed in this Booklet.
- 59) **Personal Care, Convenience and Mobile/Wearable Devices**
- a) Items for personal comfort, convenience, protection, cleanliness such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs.
 - b) First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads).
 - c) Home workout or therapy equipment, including treadmills and home gyms.
 - d) Pools, whirlpools, spas, or hydrotherapy equipment.
 - e) Hypo-allergenic pillows, mattresses, or waterbeds.

- f) Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).
 - g) Consumer wearable / personal mobile devices (such as a smart phone, smart watch, or other personal tracking devices), including any software or applications.
- 60) **Prescription Drugs** Prescription Drugs received from a Retail or Home Delivery (Mail Order) Pharmacy.
- 61) **Private Duty Nursing** Private duty nursing services.
- 62) **Prosthetics** Prosthetics for sports or cosmetic purposes.
- 63) **Residential accommodations** Residential accommodations to treat medical or behavioral health conditions, except when provided in a Hospital, Hospice, Skilled Nursing Facility, or Residential Treatment Center. This Exclusion includes procedures, equipment, services, supplies or charges for the following:
- a) Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
 - b) Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
 - c) Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included.
 - d) Services or care billed by a program or facility that principally or primarily provides services for individuals with a medical or Mental Health or Substance Use Disorder diagnosis or condition in an outdoor environment, including wilderness, adventure, outdoor programs or camps.
- 64) **Routine Physicals and Immunizations** Physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, which are not required by law under the "Preventive Care" benefit.
- 65) **Sanctioned or Excluded Providers** Any service, Drug, Drug regimen, treatment, or supply, furnished, ordered, or prescribed by a Provider identified as an excluded individual or entity on the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals/Entities (OIG List), the General Services Administration System for Award Management (GSA List), State Medicaid exclusion lists or other exclusion/sanctioned lists as published by Federal or State regulatory agencies. This exclusion does not apply to Emergency Care.
- 66) **Services Received Outside of Kentucky** Services received from a Provider outside of Kentucky. This does not apply to:
- a) Emergency or Urgent Care; or
 - b) Covered Services approved in advance by Anthem as an Authorized Service.
- 67) **Services Received Outside of the United States** Services rendered by Providers located outside the United States, unless the services are for Emergency Care, and Emergency Ambulance.
- 68) **Services for Hospital confinement primarily for diagnostic studies.**
- 69) **Sexual Dysfunction** Services or supplies for male or female sexual problems.
- 70) **Stand-By Charges** Stand-by charges of a Doctor or other Provider.
- 71) **Sterilization** Services to reverse an elective sterilization.
- 72) **Surrogate Mother Services** Services or supplies for a person not covered under this Plan for a surrogate pregnancy (including the bearing of a child by another woman for an infertile couple).

- 73) **Temporomandibular Joint Treatment** Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).
- 74) **Travel Costs** Mileage, lodging, meals, and other Member-related travel costs except as described in this Plan.
- 75) **Vein Treatment** Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.
- 76) **Vision Services** Vision services not described in the "Vision Services" benefit.
- 77) **Waived Cost-Shares Out-of-Network** For any service for which you are responsible under the terms of this Plan to pay a Copayment, Coinsurance or Deductible, and the Copayment, Coinsurance or Deductible is waived by an Out-of-Network Provider.
- 78) **Weight Loss Programs** Programs, whether or not under medical supervision, unless listed as covered in this Booklet.
- This Exclusion includes commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

Additional Information About Experimental / Investigational Services

We will find any Drug, biologic, device, diagnostic service, product, equipment, procedure, treatment, service, or supply (i.e., any service or supply) to be Experimental / Investigational if one or more of the following criteria apply when the service or supply is given:

- It cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- It has been determined by the FDA to be contraindicated for the specific use; or
- It is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or
- It is given as part of informed consent documents that describe the service or supply as Experimental / Investigational, or otherwise indicate that the safety, toxicity, or efficacy of the service or supply is under evaluation.

Any service or supply not deemed Experimental / Investigational based on the criteria above may still be deemed Experimental / Investigational. In determining whether a service or supply is Experimental / Investigational, the information described below will be considered to assess whether:

- the scientific evidence is conclusive concerning the effect of the service on health outcomes;
- the evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigational settings.

The information considered or evaluated to determine whether a service or supply is Experimental/ Investigational under the above criteria may include one or more items from the following list, which is not all inclusive:

- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, diagnostic service, product, equipment, procedure, treatment, service, or supply; or
- documents of an IRB or other similar body performing substantially the same function; or
- consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same service or supply; or
- medical records; or
- the opinions of consulting Providers and other experts in the field.

Medical policy will also be applied to identify and weigh all information and determine all questions about whether a service or supply is Experimental / Investigational.

Claims Payment

This section describes how we reimburse claims and what information is needed when you submit a claim. When you receive care from your PCP or another In-Network Provider, you do not need to file a claim because the Provider will do this for you. If you receive care from an Out-of-Network Provider, you will need to make sure a claim is filed. Many Out-of-Network Hospitals, Doctors and other Providers will file your claim for you, although they are not required to do so. If you file the claim, use a claim form as described later in this section. **Please remember that this Plan will not provide benefits for services from Out-of-Network Providers unless the claim is for Emergency Care, or for services approved in advance by Anthem as an Authorized Service.**

Maximum Allowed Amount

General

This section describes how we determine the amount of reimbursement for Covered Services. Reimbursement for services rendered by In-Network and Out-of-Network Providers is based on this Booklet's Maximum Allowed Amount for the Covered Service that you receive. Please see "Inter-Plan Arrangements" later in this section for additional information.

The Maximum Allowed Amount for this Plan is the maximum amount of reimbursement allowed for services and supplies:

- That meet the definition of Covered Services, to the extent such services and supplies are covered under your Plan and are not excluded;
- That are Medically Necessary; and
- That are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in your Booklet.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance.

Generally, services received from an Out-of-Network Provider are not covered by this Plan except for Emergency Care or when approved in advance by Anthem as an Authorized Service. Except for Surprise Billing Claims*, when you receive Covered Services from an Out-of-Network Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

**Surprise Billing Claims are described in the "Consolidated Appropriations Act of 2021 Notice" at the front of this Booklet. Please refer to that section for further details.*

When you receive Covered Services from a Provider, we will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect our determination of the Maximum Allowed Amount. Our application of these rules does not mean that the Covered Services you received were not Medically Necessary. It means we have determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same Doctor or other healthcare professional, the Plan may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the Provider is an In-Network Provider or an Out-of-Network Provider.

An In-Network Provider is a Provider who is in the managed network for this specific product or in a special Center of Excellence/or other closely managed specialty network, or who has a participation contract with us. For Covered Services performed by an In-Network Provider, the Maximum Allowed Amount for this Booklet is the rate the Provider has agreed with us to accept as reimbursement for the Covered Services. Because In-Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Please call Member Services for help in finding an In-Network Provider or visit www.anthem.com.

Providers who have not signed any contract with us and are not in any of our networks are Out-of-Network Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers. If you use an Out-of-Network Provider, your entire claim will be denied except for Emergency Care or if the services are approved in advance by Anthem as an Authorized Service.

For Covered Services you received from an Out-of-Network Provider, the Maximum Allowed Amount for this Booklet will be one of the following as determined by us:

1. An amount based on our Out-of-Network Provider fee schedule/rate, which we have established in our discretion, and which we reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar providers contracted with us, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or
2. An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, Anthem will update such information, which is unadjusted for geographic locality, no less than annually; or
3. An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers' fees and costs to deliver care, or
4. An amount negotiated by us or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management, or
5. An amount based on or derived from the total charges billed by the Out-of-Network Provider.

Providers who are not contracted for this product, but are contracted for other products with us are also considered Out-of-Network. For this Booklet, the Maximum Allowed Amount for services from these Providers will be one of the five methods shown above unless the contract between us and that Provider specifies a different amount.

For Covered Services rendered outside Anthem's Service Area by Out-of-Network Providers, claims may be priced using the local Blue Cross Blue Shield plan's non-participating provider fee schedule / rate or the pricing arrangements required by applicable state or federal law. In certain situations, the Maximum Allowed Amount for out of area claims may be based on billed charges, the pricing we would use if the healthcare services had been obtained within the Anthem Service Area, or a special negotiated price.

Unlike In-Network Providers, Out-of-Network Providers may send you a bill and collect for the amount of the Provider's charge that exceeds the Maximum Allowed Amount unless your claim involves a Surprise Billing Claim. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Please call Member Services for help in finding an In-Network Provider or visit our website at www.anthem.com.

Member Services is also available to assist you in determining this Booklet's Maximum Allowed Amount for a particular service from an Out-of-Network Provider. In order for us to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate your out of pocket responsibility. Although Member Services can assist you with this pre-service information, the final Maximum Allowed Amount for your claim will be based on the actual claim submitted by the Provider.

Member Cost Share

For certain Covered Services and depending on your Plan design, you may be required to pay a part of the Maximum Allowed Amount as your cost share amount (for example, Deductible, Copayment, and/or Coinsurance).

The Plan will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by your Provider for non-Covered Services, regardless of whether such services are performed by an In-Network or Out-of-Network Provider. Non-covered services include services specifically excluded from coverage by the terms of your Plan and received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits.

Authorized Services

In some circumstances, such as where there is no In-Network Provider available for the Covered Service, we may authorize the In-Network cost share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service you receive from an Out-of-Network Provider. In such circumstances, you must contact us in advance of obtaining the Covered Service. If we authorize an In-Network cost share amount to apply to a Covered Service received from an Out-of-Network Provider, you may also still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge unless your claim is a Surprise Billing Claim. Please contact Member Services for Authorized Services information or to request authorization.

Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee. If applicable, we will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

Notice of Claim & Proof of Loss

After you get Covered Services, we must receive written notice of your claim in order for benefits to be paid.

- In-Network Providers will submit claims for you. They are responsible for ensuring that claims have the information we need to determine benefits. If the claim does not include enough information, we

will ask them for more details, and they will be required to supply those details within certain timeframes.

- Out-of-Network claims can be submitted by the Provider if the Provider is willing to file on your behalf. However, if the Provider is not submitting on your behalf, you will be required to submit the claim. Claim forms are usually available from the Provider. If they do not have a claims form, you can send a written request to us, or contact Member Services and ask for a claims form to be sent to you. We will send the form to you within 15 days. If you do not receive the claims form within 15 days, you can still submit written notice of the claim without the claim form. The same information that would be given on the claim form must be included in the written notice of claim, including:
 - Name of patient.
 - Patient's relationship with the Subscriber.
 - Identification number.
 - Date, type, and place of service.
 - Your signature and the Provider's signature.

Out-of-Network claims must be submitted within 90 days. In certain cases, state or federal law may allow additional time to file a claim, if you could not reasonably file within the 90-day period. The claim must have the information we need to determine benefits. If the claim does not include enough information, we will ask you for more details and inform you of the time by which we need to receive that information. Once we receive the required information, we will process the claim according to the terms of your Plan.

Claims will be paid within 30 days of the date we get the completed claim and proof of loss.

Please note that failure to submit the information we need by the time listed in our request could result in the denial of your claim, unless state or federal law requires an extension. Please contact Member Services if you have any questions or concerns about how to submit claims.

Member's Cooperation

You will be expected to complete and submit to us all such authorizations, consents, releases, assignments and other documents that may be needed in order to obtain or assure reimbursement under Medicare, Workers' Compensation or any other governmental program. If you fail to cooperate, you will be responsible for any charge for services. Please note that once we become aware of your eligibility for Medicare, we will pay claims as if you had enrolled in Medicare, even if you did not.

Payment of Benefits

You authorize the Claims Administrator, in its own discretion and on behalf of the Employer, to make payments directly to Providers for Covered Services. In no event, however, shall the Plan's right to make payments directly to a Provider be deemed to suggest that any Provider is a beneficiary with independent claims and appeal rights under the Plan. The Claims Administrator also reserves the right, in its own discretion, to make payments directly to you as opposed to any Provider for Covered Services, except for claims for Emergency Care or Surprise Billing Claims for air ambulance services or non-Emergency services performed by Out-of-Network Providers at certain In-Network Facilities, which will be paid directly to Providers and Facilities. In the event that payment is made directly to you, you have the responsibility to apply this payment to the claim from the Out-of-Network Provider. Payments and notice regarding the receipt and/or adjudication of claims may also be sent to an Alternate Recipient (which is defined herein as any child of a Subscriber who is recognized under a "Qualified Medical Child Support Order" as having a right to enrollment under the Employer's Plan), or that person's custodial parent or designated representative. Any payments made by the Claims Administrator (whether to any Provider for

Covered Service or You) will discharge the Plan's obligation to pay for Covered Services. You cannot assign your right to receive payment to anyone, except as required by a "Qualified Medical Child Support Order" as defined by, and if subject to, ERISA or any applicable Federal law.

Once a Provider performs a Covered Service, the Claims Administrator will not honor a request to withhold payment of the claims submitted.

The coverage, rights, and benefits under the Plan are not assignable by any Member without the written consent of the Plan, except as provided above. This prohibition against assignment includes rights to receive payment, claim benefits under the Plan and/or law, sue or otherwise begin legal action, or request Plan documents or any other information that a Participant or beneficiary may request under ERISA. Any assignment made without written consent from the Plan will be void and unenforceable.

Inter-Plan Arrangements

Out-of-Area Services

Overview

We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services outside the geographic area we serve (the "Anthem Service Area"), the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside of the Anthem Service Area, you will receive it from one of two kinds of Providers. Most Providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some Providers ("nonparticipating providers") don't contract with the Host Blue. We explain below how we pay both kinds of Providers.

Anthem covers only limited healthcare services received outside of the Anthem Service Area. For example, Emergency or Urgent Care obtained outside the Anthem Service Area is always covered. Any other services will not be covered when processed through any Inter-Plan Arrangements, unless authorized by Anthem.

Inter-Plan Arrangements Eligibility – Claim Types

Most claim types are eligible to be processed through Inter-Plan Arrangements, as described above. Examples of claims that are not included are Prescription Drugs that you obtain from a Pharmacy and most dental or vision benefits.

A. BlueCard® Program

Under the BlueCard® Program, when you receive Covered Services within the geographic area served by a Host Blue, we will still fulfill our contractual obligations. But, the Host Blue is responsible for: (a) contracting with its Providers; and (b) handling its interactions with those Providers.

When you receive Covered Services outside the Anthem Service Area and the claim is processed through the BlueCard Program, the amount you pay is calculated based on the lower of:

- The billed charges for Covered Services; or
- The negotiated price that the Host Blue makes available to Us.

Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with that Provider. Sometimes, such an arrangement may be an average price, based on a discount that results in expected average savings for services provided by similar types of Providers. Estimated and average pricing arrangements may also involve types of settlements, incentive payments and/or other credits or charges.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price we used for your claim because they will not be applied after a claim has already been paid.

B. Special Cases: Value-Based Programs

BlueCard® Program

If you receive Covered Services under a Value-Based Program inside a Host Blue’s Service Area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Anthem through average pricing or fee schedule adjustments. Additional information is available upon request.

C. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee. If applicable, we will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

D. Nonparticipating Providers Outside Our Service Area

1. Allowed Amounts and Member Liability Calculation

When Covered Services are provided outside of Anthem’s Service Area by non-participating providers, we may determine benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable state or federal law. In these situations, the amount you pay for such services as Deductible, Copayment or Coinsurance will be based on that allowed amount. Also, you may be responsible for the difference between the amount that the non-participating provider bills and the payment we will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network Emergency services.

2. Exceptions

In certain situations, we may use other pricing methods, such as billed charges or the pricing we would use if the healthcare services had been obtained within the Anthem Service Area, or a special negotiated price to determine the amount we will pay for services provided by nonparticipating providers. In these situations, you may be liable for the difference between the amount that the nonparticipating provider bills and the payment we make for the Covered Services as set forth in this paragraph.

E. Blue Cross Blue Shield Global Core® Program

If you plan to travel outside the United States, call Member Services to find out your Blue Cross Blue Shield Global Core® benefits. Benefits for services received outside of the United States may be different from services received in the United States. The Plan only covers Emergency Care, including ambulance, and Urgent Care outside of the United States. Remember to take an up to date health ID card with you.

When you are traveling abroad and need medical care, you can call the Blue Cross Blue Shield Global Core® Service Center any time. They are available 24 hours a day, seven days a week. The toll free number is 800-810-2583. Or you can call them collect at 804-673-1177.

Keep in mind, if you need Emergency medical care, go to the nearest hospital. There is no need to call before you receive care.

Please refer to the “Getting Approval for Benefits” section in this Booklet for further information.

How Claims are Paid with Blue Cross Blue Shield Global Core®

In most cases, when you arrange inpatient hospital care with Blue Cross Blue Shield Global Core®, claims will be filed for you. The only amounts that you may need to pay up front are any Copayment, Coinsurance or Deductible amounts that may apply.

You will typically need to pay for the following services up front:

- Doctors services;
- Inpatient hospital care not arranged through Blue Cross Blue Shield Global Core®; and
- Outpatient services.

You will need to file a claim form for any payments made up front.

When you need Blue Cross Blue Shield Global Core® claim forms you can get international claims forms in the following ways:

- Call the Blue Cross Blue Shield Global Core® Service Center at the numbers above; or
- Online at www.bcbsglobalcore.com.

You will find the address for mailing the claim on the form.

Coordination of Benefits When Members Are Insured Under More Than One Plan

Applicability

This provision applies when you have health or dental care coverage under more than one Plan. For the purposes of this provision, "Plan" is defined below.

If this provision applies, the Order of Benefit Determination Rules specify whether the benefits of this Plan are determined before or after those of another Plan. The benefits of this Plan:

1. Will not be reduced when, under the Order of Benefit Determination Rules, this Plan determines its benefits before another Plan; but
2. May be reduced when, under the Order of Benefit Determination Rules, another Plan determines its benefits first. The reduction is described under the heading "Effects on the Benefits of this Plan."

Definitions

Plan - this Plan and any other arrangement providing health or dental care or benefits for health or dental care through:

1. Group insurance or group-type coverage whether insured or uninsured. This shall not include the medical benefits coverage in a group, group-type, and individual motor vehicle "no-fault" and traditional automobile "fault" type contracts. This does include prepayment group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
2. Individual insurance for individual-type coverage. This includes prepayment, group practice, or individual practice coverage.
3. Coverage under a governmental Plan or coverage required or provided by law except Medicaid.
4. Any other coverage which, as defined by the Employee Retirement Income Security Act of 1974, is a labor-management trustee Plan, a union welfare Plan, an employee organization Plan or an employee benefit organization.
5. Any other coverage provided because of sponsorship by or membership in any other association, union, or similar organization.

"Plan" does not include any of the following:

1. Group or group-type fixed indemnity medical expense reimbursement policies.
2. School accident-type coverage for grammar, high school, and college students for accidents only, including athletic injuries, either on a 24 hour basis or on a "to and from" school basis.

Primary Plan/Secondary Plan - the Order of Benefit Determination Rules state whether this Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.

Primary plan means a plan whose benefits shall be determined without taking the existence of any other plan into consideration if:

1. The plan either has no order of benefits determination requirements, or

2. All plans that cover the person use the order of benefits determination requirements as listed in the Order of Benefit Determination Rules section.

When this Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

When this Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

When there are more than two Plans covering the person, this Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

Allowable Expense - a health or dental care service or expense including Deductibles, Coinsurance or Copayment, that is covered in full or in part by any of the plans covering the person.

The difference between the cost of a private Hospital room and the cost of a semiprivate Hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private Hospital room is Medically Necessary either in terms of accepted medical practice or as specifically defined in this Plan.

When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

When the benefits are reduced under a Primary Plan because a Member does not comply with the Plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, Precertification of admissions or services, and Preferred Provider arrangements. Only benefit reductions based upon provisions similar to this one and which are contained in the Primary Plan may be excluded from Allowable Expenses. This provision shall not be used by a Secondary Plan to refuse to pay benefits because a health maintenance organization (HMO) member has elected to have health care services provided by a non-HMO provider and the HMO, pursuant to its Contract, is not obligated to pay for providing those services.

Allowable Expense does not include any expenses incurred or claims made under the Prescription Drug program of this Plan.

Allowable Expense does not include the amount that is subject to the Primary high-deductible health plan's deductible, if we have been advised by you that all Plans covering you are high-deductible health plans and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986.

The Plan shall be secondary in coverage to any medical payments provision, no-fault automobile insurance policy, or personal injury protection policy regardless of any election made by anyone to the contrary. The Plan shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies. This provision applies notwithstanding any coordination of benefits term to the contrary.

Order of Benefit Determination Rules

When there is a basis for a claim under this Plan and another Plan, this Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:

1. The other Plan has rules coordinating its benefits with those of this Plan; and
2. Both those rules and this Plan's rules require that this Plan's benefits be determined before those of the other Plan.

This Plan determines its order of benefits using the first of the following rules which applies:

1. Non-Dependent/Dependent. The benefits of the Plan which covers the person as an employee, Subscriber or Subscriber (that is, other than as a Dependent) are determined before those of the Plan which covers the person as a Dependent.
2. Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one Plan the order of benefits is determined as follows:
 - A. For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
 1. The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
 2. If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
 - B. For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
 1. If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
 2. If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of 1. above will determine the order of benefits;
 3. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 1. above will determine the order of benefits; or
 4. If there is no court decree assigning responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - a. The Plan covering the Custodial parent;
 - b. The Plan covering the spouse of the Custodial parent;
 - c. The Plan covering the non-custodial parent; and then
 - d. The Plan covering the spouse of the non-custodial parent.
3. For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of item 1. above will determine the order of benefits as if those individuals were the parents of the child.
4. Joint Custody. If the specific terms of a court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the Order of Benefit Determination Rules outlined in paragraph 2.

5. **Active/Inactive Subscriber.** The benefits of a Plan which covers a person as an employee who is neither laid off nor retired or as that employee's Dependent are determined before those of a Plan which covers that person as a laid off or retired employee or as that employee's Dependent. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule 5 is ignored. This rule does not supersede rule 1 above.
6. **Continuation Coverage.** If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Plan, the following shall be the order of benefit determination:
 - a. First, the benefits of a Plan covering the person as an employee, Subscriber or Subscriber or as that person's Dependent;
 - b. Second, the benefits under the continuation coverage. If the other Plan does not have the rule described above and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
7. **Longer/Shorter Length of Coverage.** If none of the above rules determines the order of benefits, the benefits of the Plan which covered the person longer are determined before those of the Plan which covered that person for the shorter term. If none of the preceding rules determines the Primary Plan, the Allowable Expenses shall be shared equally between the Plans.

Effect on this Plan's Benefits

When a Member is covered under two or more Plans which together pay more than the Allowable Expense, the Plan will pay this Plan's benefits according to the Order of Benefit Determination Rules. This Plan's benefit payments will not be affected when it is Primary. However, when this Plan is Secondary under the Order of Benefit Determination Rules, benefits payable will be reduced, if necessary, so that combined benefits of all Plans covering you or your Dependent do not exceed the Allowable Expense.

When this Plan is Secondary, you will receive credit during the calendar year for the amount by which your benefits are reduced. This credit will not be applied to the extent that would cause you to receive:

1. A combined benefit from all Plans greater than the Allowable Expense; or
2. More benefits during a calendar year than you would receive if there were no other coverage.

When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

Right to Receive and Release Needed Information

Certain facts are needed to apply these rules. We have the right to decide which facts we need. We may get needed facts from or give them to any other organization or person. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give us any facts we need to pay the claim.

Facility of Payment

A payment made under another Plan may include an amount which should have been paid under this Plan. If it does, this Plan may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this Plan. This Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in

which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payment made by this Plan is more than it should have paid under this provision, this Plan may recover the excess from one or more of:

1. The persons this Plan has paid or for whom this Plan has paid;
2. Insurance companies; or
3. Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefit provided in the form of services.

Subrogation and Reimbursement

These Subrogation and Reimbursement provisions apply when the Plan pays benefits as a result of injuries or illnesses You sustained, and You have a right to a Recovery or have received a Recovery from any source.

Definitions

As used in these Subrogation and Reimbursement provisions, “You” or “Your” includes anyone on whose behalf the plan pays benefits. These Subrogation and Reimbursement provisions apply to all current or former plan participants and plan beneficiaries. The provisions also apply to the parents, guardian, or other representative of a dependent child who incurs claims and is or has been covered by the Plan. The Plan’s rights under these provisions shall also apply to the personal representative or administrator of Your estate, Your heirs or beneficiaries, minors, and legally incompetent or disabled persons. If the covered person is a minor, any amount recovered by the minor, the minor’s trustee, guardian, parent, or other representative, shall be subject to these Subrogation and Reimbursement provisions. Likewise, if the covered person’s relatives, heirs, and/or assignees make any Recovery because of injuries sustained by the covered person, or because of the death of the covered person, that Recovery shall be subject to this provision, regardless of how any Recovery is allocated or characterized.

As used in these Subrogation and Reimbursement provisions, “Recovery” includes, but is not limited to, monies received from any person or party, any person’s or party’s liability insurance coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, workers’ compensation insurance or fund, premises medical payments coverage, restitution, or “no-fault” or personal injury protection insurance and/or automobile medical payments coverage, or any other first or third party insurance coverage, whether by lawsuit, settlement or otherwise. Regardless of how You or Your representative or any agreements allocate or characterize the money You receive as a Recovery, it shall be subject to these provisions.

Subrogation

Immediately upon paying or providing any benefit under the Plan, the Plan shall be subrogated to, or stand in the place of, all of Your rights of recovery with respect to any claim or potential claim against any party, due to an injury, illness or condition to the full extent of benefits provided or to be provided by the Plan. The Plan has the right to recover payments it makes on Your behalf from any party or insurer responsible for compensating You for Your illnesses or injuries. The Plan has the right to take whatever legal action it sees fit against any person, party, or entity to recover the benefits paid under the Plan. The Plan may assert a claim or file suit in Your name and take appropriate action to assert its subrogation claim, with or without Your consent. The Plan is not required to pay You part of any recovery it may obtain, even if it files suit in Your name.

Reimbursement

If You receive any payment as a result of an injury, illness or condition, You agree to reimburse the Plan first from such payment for all amounts the Plan has paid and will pay as a result of that injury, illness or condition, up to and including the full amount of Your recovery. If You obtain a Recovery and the Plan has not been repaid for the benefits the Plan paid on Your behalf, the Plan shall have a right to be repaid from the Recovery in the amount of the benefits paid on Your behalf. You must promptly reimburse the Plan from any Recovery to the extent of benefits the Plan paid on Your behalf regardless of whether the payments You receive make You whole for Your losses, illnesses and/or injuries.

Secondary to Other Coverage

The Plan shall be secondary in coverage to any medical payments provision, no-fault automobile insurance policy, or personal injury protection policy regardless of any election made by You to the contrary. The Plan

shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies. This provision applies notwithstanding any coordination of benefits term to the contrary.

Assignment

In order to secure the Plan's rights under these Subrogation and Reimbursement Provisions, You agree to assign to the Plan any benefits or claims or rights of recovery You have under any automobile policy or other coverage, to the full extent of the Plan's subrogation and reimbursement claims. This assignment allows the Plan to pursue any claim You may have regardless of whether You choose to pursue the claim.

Applicability to All Settlements and Judgments

Notwithstanding any allocation or designation of Your Recovery made in any settlement agreement, judgment, verdict, release, or court order, the Plan shall have a right of full recovery, in first priority, against any Recovery You make. Furthermore, the Plan's rights under these Subrogation and Reimbursement provisions will not be reduced due to Your own negligence. The terms of these Subrogation and Reimbursement provisions shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the terms of any settlement, judgment, or verdict pertaining to Your Recovery identify the medical benefits the Plan provided or purport to allocate any portion of such Recovery to payment of expenses other than medical expenses. The Plan is entitled to recover from any Recovery, even those designated as being for pain and suffering, non-economic damages, and/or general damages only.

Constructive Trust

By accepting benefits from the Plan, You agree that if You receive any payment as a result of an injury, illness or condition, You will serve as a constructive trustee over those funds. You and Your legal representative must hold in trust for the Plan the full amount of the Recovery to be paid to the Plan immediately upon receipt. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the Plan. Any Recovery You obtain must not be dissipated or disbursed until such time as the Plan has been repaid in accordance with these Subrogation and Reimbursement provisions.

Lien Rights

The Plan will automatically have a lien to the extent of benefits paid by the Plan for the treatment of Your illness, injury or condition upon any Recovery related to treatment for any illness, injury or condition for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds from Your Recovery including, but not limited to, you, your representative or agent, and/or any other source possessing funds from Your Recovery. You and Your legal representative acknowledge that the portion of the Recovery to which the Plan's equitable lien applies is a Plan asset. The Plan shall be entitled to equitable relief, including without limitation restitution, the imposition of a constructive trust or an injunction, to the extent necessary to enforce the Plan's lien and/or to obtain (or preclude the transfer, dissipation or disbursement of) such portion of any Recovery in which the Plan may have a right or interest.

First-Priority Claim

By accepting benefits from the Plan, You acknowledge the Plan's rights under these Subrogation and Reimbursement provisions are a first priority claim and are to be repaid to the Plan before You receive any Recovery for your damages. The Plan shall be entitled to full reimbursement on a first-dollar basis from any Recovery, even if such payment to the Plan will result in a Recovery which is insufficient to make You whole or to compensate You in part or in whole for the losses, injuries, or illnesses You sustained. The "made-whole" rule does not apply. To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Plan's subrogation claim and any claim held by You, the Plan's subrogation claim shall be first satisfied before any part of a Recovery is applied to Your claim, Your attorney fees, other

expenses or costs. The Plan is not responsible for any attorney fees, attorney liens, other expenses or costs You incur. The "common fund" doctrine does not apply to any funds recovered by any attorney You hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

Cooperation

You agree to cooperate fully with the Plan's efforts to recover benefits paid. The duty to cooperate includes, but is not limited, to the following:

- You must promptly notify the Plan of how, when and where an accident or incident resulting in personal injury or illness to You occurred, all information regarding the parties involved and any other information requested by the Plan.
- You must notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of Your intention to pursue or investigate a claim to recover damages or obtain compensation due to Your injury, illness or condition.
- You must cooperate with the Plan in the investigation, settlement and protection of the Plan's rights. In the event that You or Your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation or reimbursement rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.
- You and your agents shall provide all information requested by the Plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request and all documents related to or filed in personal injury litigation.
- You recognize that to the extent that the Plan paid or will pay benefits under a capitated agreement, the value of those benefits for purposes of these provisions will be the reasonable value of those payments or the actual paid amount, whichever is higher.
- You must not do anything to prejudice the Plan's rights under these Subrogation and Reimbursement provisions. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan.
- You must send the Plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to You.
- You must promptly notify the Plan if You retain an attorney or if a lawsuit is filed on Your behalf.
- You must immediately notify the Plan if a trial is commenced, if a settlement occurs or if potentially dispositive motions are filed in a case.

In the event that You or Your legal representative fails to do whatever is necessary to enable the Plan to exercise its rights under these Subrogation and Reimbursement provisions, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.

If You fail to repay the Plan, the Plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of Your Recovery whichever is less, from any future benefit under the Plan if:

1. The amount the Plan paid on Your behalf is not repaid or otherwise recovered by the Plan; or
2. You fail to cooperate.

In the event You fail to disclose the amount of Your settlement to the Plan, the Plan shall be entitled to deduct the amount of the Plan's lien from any future benefit under the Plan.

The Plan shall also be entitled to recover any of the unsatisfied portion of the amount the Plan has paid or the amount of Your Recovery, whichever is less, directly from the Providers to whom the Plan has made payments on Your behalf. In such a circumstance, it may then be Your obligation to pay the Provider the full billed amount, and the Plan will not have any obligation to pay the Provider or reimburse You.

You acknowledge the Plan has the right to conduct an investigation regarding the injury, illness or condition to identify potential sources of recovery. The Plan reserves the right to notify all parties and their agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

You acknowledge the Plan has notified you that it has the right pursuant to the Health Insurance Portability & Accountability Act ("HIPAA"), 42 U.S.C. Section 1301 *et seq*, to share Your personal health information in exercising these Subrogation and Reimbursement provisions.

The Plan is entitled to recover its attorney's fees and costs incurred in enforcing its rights under these Subrogation and Reimbursement provisions.

Discretion

The Plan Administrator has sole discretion to interpret the terms of the Subrogation and Reimbursement provisions of this Plan in its entirety and reserves the right to make changes as it deems necessary.

Your Right to Appeal

We want your experience with us to be as positive as possible. There may be times, however, when you have a complaint, problem, or question about your Plan or a service you have received. In those cases, please contact Member Services by calling the number on the back of your ID card.

For purposes of these Appeal provisions, "claim for benefits" means a request for benefits under the Plan. The term includes both pre-service and post-service claims.

- A pre-service claim is a claim for benefits under the Plan for which you have not received the benefit or for which you may need to obtain approval in advance.
- A post-service claim is any other claim for benefits under the Plan for which you have received the service.

If your claim is denied or if your coverage is rescinded:

- You will be provided with a written notice of the denial or rescission; and
- You are entitled to a full and fair review of the denial or rescission.

The procedure we will follow will satisfy the requirements for a full and fair review under applicable federal regulations.

Notice of Adverse Benefit Determination

If your claim is denied, our notice of the adverse benefit determination (denial) will include:

- information sufficient to identify the claim involved;
- the specific reason(s) for the denial;
- a reference to the specific Plan provision(s) on which the our determination is based;
- a description of any additional material or information needed to perfect your claim;
- an explanation of why the additional material or information is needed;
- a description of the Plan's review procedures and the time limits that apply to them, including a statement of your right to bring a civil action under ERISA within one year of the appeal decision if you submit an appeal and the claim denial is upheld.
- information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and about your right to request a copy of it free of charge, along with a discussion of the claims denial decision;
- information about the scientific or clinical judgment for any determination based on Medical Necessity or Experimental treatment, or about your right to request this explanation free of charge, along with a discussion of the claims denial decision; and
- information regarding your potential right to an External Appeal pursuant to federal law.

For claims involving urgent/concurrent care:

- our notice will also include a description of the applicable urgent/concurrent review process; and
- we may notify you or your authorized representative within 72 hours orally and then furnish a written notification.

Appeals

You have the right to appeal an adverse benefit determination (claim denial or rescission of coverage). You or your authorized representative must file your appeal within 180 calendar days after you are notified of the denial or rescission. You will have the opportunity to submit written comments, documents, records, and other information supporting your claim. Our review of your claim will take into account all

information you submit, regardless of whether it was submitted or considered in the initial benefit determination.

We shall offer a single mandatory level of appeal and an additional voluntary second level of appeal which may be a panel review, independent review, or other process consistent with the entity reviewing the appeal. The time frame allowed for us to complete our review is dependent upon the type of review involved (e.g. pre-service, concurrent, post-service, urgent, etc.).

For pre-service claims involving urgent/concurrent care, you may obtain an expedited appeal. You or your authorized representative may request it orally or in writing. All necessary information, including our decision, can be sent between us and you by telephone, facsimile or other similar method. To file an appeal for a claim involving urgent/concurrent care, you or your authorized representative must contact us at the number shown on your identification card and provide at least the following information:

- the identity of the claimant;
- The date (s) of the medical service;
- the specific medical condition or symptom;
- the Provider's name;
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

All other requests for appeals should be submitted in writing by the Member or the Member's authorized representative, except where the acceptance of oral appeals is otherwise required by the nature of the *appeal* (e.g. urgent care). You or your authorized representative must submit a request for review to:

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

You must include Your Member Identification Number when submitting an appeal.

Upon request, we will provide, without charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. "Relevant" means that the document, record, or other information:

- was relied on in making the benefit determination; or
- was submitted, considered, or produced in the course of making the benefit determination; or
- demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the Plan, applied consistently for similarly-situated claimants; or
- is a statement of the Plan's policy or guidance about the treatment or benefit relative to your diagnosis.

We will also provide you, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with your claim. In addition, before you receive an adverse benefit determination on review based on a new or additional rationale, we will provide you, free of charge, with the rationale.

For Out of State Appeals You have to file Provider appeals with the Host Plan. This means Providers must file appeals with the same plan to which the claim was filed.

How Your Appeal will be Decided

When we consider your appeal, we will not rely upon the initial benefit determination or, for voluntary second-level appeals, to the earlier appeal determination. The review will be conducted by an appropriate reviewer who did not make the initial determination and who does not work for the person who made the initial determination. A voluntary second-level review will be conducted by an appropriate reviewer who did not make the initial determination or the first-level appeal determination and who does

not work for the person who made the initial determination or first-level appeal determination.

If the denial was based in whole or in part on a medical judgment, including whether the treatment is Experimental, Investigational, or not Medically Necessary, the reviewer will consult with a health care professional who has the appropriate training and experience in the medical field involved in making the judgment. This health care professional will not be one who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination.

Notification of the Outcome of the Appeal

If you appeal a claim involving urgent/concurrent care, we will notify you of the outcome of the appeal as soon as possible, but not later than 72 hours after receipt of your request for appeal.

If you appeal any other pre-service claim, we will notify you of the outcome of the appeal within 30 days after receipt of your request for appeal.

If you appeal a post-service claim, we will notify you of the outcome of the appeal within 60 days after receipt of your request for appeal.

Appeal Denial

If your appeal is denied, that denial will be considered an adverse benefit determination. The notification from us will include all of the information set forth in the above section entitled "Notice of Adverse Benefit Determination."

If we fail to resolve the appeal with the required time, you may pursue external review as described later in this section. This option is not available, however, if our failure to resolve the appeal is due to a de minimus violation that does not cause harm to you or is not likely to cause prejudice or harm to you, if the delay is for good cause or due to matters beyond our control, and is part of an ongoing, good faith exchange of information between you and us.

Voluntary Second Level Appeals

If you are dissatisfied with the mandatory first level appeal decision, a voluntary second level appeal may be available. If you would like to initiate a second level appeal, please write to the address listed above. Voluntary appeals must be submitted within 60 calendar days of the denial of the first level appeal. You are not required to complete a voluntary second level appeal prior to submitting a request for an independent External Review.

Voluntary Third Level Appeals

After you have received a voluntary second level appeal, you have the right to request in writing, a voluntary third level appeal through the University of Kentucky. You have 30 days to submit a request for a third level of review. Send a written request to: The Associate Vice President, Human Resource Services, The University of Kentucky, 101 Scovell Hall, Lexington, KY 40506. Include any additional information you have that supports the request. You don't have to send the information from the first or second level appeal.

External Review

If the outcome of the mandatory first level appeal is adverse to you and it was based on medical judgment, or if it pertained to a rescission of coverage, you may be eligible for an independent External Review pursuant to federal law. You must submit your request for External Review to us within four (4) months of the notice of your final internal adverse determination.

A request for an External Review must be in writing unless we determine that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted for internal

appeal. However, you are encouraged to submit any additional information that you think is important for review.

For pre-service claims involving urgent/concurrent care, you may proceed with an Expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through our internal appeal process. You or your authorized representative may request it orally or in writing. All necessary information, including our decision, can be sent between us and you by telephone, facsimile or other similar method. To proceed with an Expedited External Review, you or your authorized representative must contact us at the number shown on your identification card and provide at least the following information:

- the identity of the claimant;
- The date (s) of the medical service;
- the specific medical condition or symptom;
- the Provider's name;
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

All other requests for External Review should be submitted in writing unless we determine that it is not reasonable to require a written statement. Such requests should be submitted by you or your authorized representative to:

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

You must include Your Member Identification Number when submitting an appeal.

This is not an additional step that you must take in order to fulfill your appeal procedure obligations described above. Your decision to seek External Review will not affect your rights to any other benefits under this health care Plan. There is no charge for you to initiate an independent External Review. The External Review decision is final and binding on all parties except for any relief available through applicable state laws or ERISA.

Requirement to file an Appeal before filing a lawsuit

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced within one year of the Plan's final decision on the claim or other request for benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the internal Appeals Procedure but not including any voluntary level of appeal, before filing a lawsuit or taking other legal action of any kind against the Plan. If your health benefit Plan is sponsored by your Employer and subject to the Employee Retirement Income Security Act of 1974 (ERISA) and your appeal as described above results in an adverse benefit determination, you have a right to bring a civil action under Section 502(a) of ERISA within one year of the appeal decision.

We reserve the right to modify the policies, procedures and timeframes in this section upon further clarification from Department of Health and Human Services and Department of Labor.

Eligibility and Enrollment – Adding Members

In this section you will find information on who is eligible for coverage under this Plan and when Members can be added to your coverage. Eligibility requirements are described in general terms below. For more specific information, please see your Human Resources or Benefits Department.

Who is Eligible for Coverage

The Subscriber

To be eligible to enroll as a Subscriber, the individual must:

- Be an employee, member, or retiree of the Employer, and:
- Be entitled to participate in the benefit Plan arranged by the Employer;
- Have satisfied any probationary or waiting period established by the Employer and (for non-retirees) perform the duties of your principal occupation for the Employer;
- Reside or work in the Service Area
- An eligible Retiree, defined as a retiree who is:
 - Retired in accordance with University of Kentucky retirement regulations; early retirees may retain coverage on the same basis as an Employee until he or she becomes eligible for Medicare.

On-Call Employees are NOT eligible for coverage under the Plan unless in the “Premium” on-call program or qualified by the Affordable Care Act definition.

Dependents

To be eligible to enroll as a Dependent, you must be listed on the enrollment form completed by the Subscriber, meet all Dependent eligibility criteria established by the Employer, and be one of the following:

- The Subscriber's spouse. For information on spousal eligibility please contact the Employer.
- The Subscriber's Domestic Partner, if Domestic Partner coverage is allowed under the Employer's Plan. Please contact the Employer to determine if Domestic Partners are eligible under this Plan. Domestic Partner, or Domestic Partnership means a person of the same or opposite sex who has signed the Domestic Partner Affidavit certifying that he or she is the Subscriber's sole Domestic Partner and has been for 12 months or more; he or she is mentally competent; he or she is not related to the Subscriber by blood closer than permitted by state law for marriage; he or she is not married to anyone else; and he or she is financially interdependent with the Subscriber.

For purposes of this Plan, a Domestic Partner shall be treated the same as a spouse, and a Domestic Partner's child, adopted child, or child for whom a Domestic Partner has legal guardianship shall be treated the same as any other child.

Any federal or state law that applies to a Member who is a spouse or child under this Plan shall also apply to a Domestic Partner or a Domestic Partner's child who is a Member under this Plan. This includes but is not limited to, COBRA, FMLA, and COB. A Domestic Partner's or a Domestic Partner's child's coverage ends on the date of dissolution of the Domestic Partnership.

To apply for coverage as Domestic Partners, both the Subscriber and the Domestic Partner must complete and sign the Affidavit of Domestic Partnership in addition to the Enrollment Application, and must meet all criteria stated in the Affidavit. Signatures must be witnessed and notarized by a notary public. The Employer reserves the right to make the ultimate decision in determining eligibility of the Domestic Partner.

- The Subscriber's or the Subscriber's spouse's children, including natural children, stepchildren, newborn and legally adopted children and children who the Employer has determined are covered under a Qualified Medical Child Support Order as defined by ERISA or any applicable state law.
- Children for whom the Subscriber or the Subscriber's spouse is a legal guardian or as otherwise required by law.

All enrolled eligible children will continue to be covered until the age limit listed in the Schedule of Benefits. Coverage may be continued past the age limit in the following circumstances:

- For those already enrolled unmarried Dependents who cannot work to support themselves due to a mental or physical impairment. The Dependent's incapacity must start before the end of the period they would become ineligible for coverage. We must be informed of the Dependent's eligibility for continuation of coverage within 31 days after the Dependent would normally become ineligible. You must then give proof as often as we require. This will not be more often than once a year after the two-year period following the child reaching the limiting age. You must give the proof at no cost to us. You must notify us if the Dependent's marital status changes and they are no longer eligible for continued coverage.

You may be required to give proof of continued eligibility for any enrolled child. Your failure to give this information could result in termination of a child's coverage.

To obtain coverage for children, you may be required to give us a copy of any legal documents awarding guardianship of such child(ren) to you.

Types of Coverage

Your Employer offers the enrollment options listed below. After reviewing the available options, you may choose the option that best meets your needs. The options are as follows:

- Subscriber only (also referred to as single coverage);
- Subscriber and spouse or Domestic Partner;
- Subscriber and one child;
- Subscriber and children;
- Subscriber and family.

If an Employee or retiree dies while covered under this Plan, the surviving Spouse and any eligible Dependent children may continue coverage when they meet the University of Kentucky's survivorship qualifications.

When You Can Enroll

Initial Enrollment

The Employer will offer an initial enrollment period to new Subscribers and their Dependents when the Subscriber is first eligible for coverage. Coverage will be effective based on the waiting period chosen by the Employer, and will not exceed 90 days.

If you did not enroll yourself and/or your Dependents during the initial enrollment period you will only be able to enroll during an Open Enrollment period or during a Special Enrollment period, as described below.

Open Enrollment

Open Enrollment refers to a period of time, usually 60 days, during which eligible Subscribers and Dependents can apply for or change coverage. Open Enrollment occurs only once per year. The Employer will notify you when Open Enrollment is available.

Special Enrollment Periods

If a Subscriber or Dependent does not apply for coverage when they were first eligible, they may be able to join the Plan prior to Open Enrollment if they qualify for Special Enrollment. Except as noted otherwise below, the Subscriber or Dependent must request Special Enrollment within 31 days of a qualifying event.

Special Enrollment is available for eligible individuals who:

- Lost eligibility under a prior health plan for reasons other than non-payment of Fees or due to fraud or intentional misrepresentation of a material fact.
- Exhausted COBRA benefits or stopped receiving group contributions toward the cost of the prior health plan.
- Lost employer contributions towards the cost of the other coverage.
- Are now eligible for coverage due to marriage, birth, adoption, or placement for adoption.

Important Notes about Special Enrollment:

- Members who enroll during Special Enrollment are **not** considered Late Enrollees.
- Individuals must request coverage within 31 days of a qualifying event (i.e., marriage, exhaustion of COBRA, etc.).

Medicaid and Children's Health Insurance Program Special Enrollment

Eligible Subscribers and Dependents may also enroll under two additional circumstances:

- The Subscriber's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- The Subscriber or Dependent becomes eligible for a subsidy (state premium assistance program)

The Subscriber or Dependent must request Special Enrollment within 60 days of the above events.

Late Enrollees

If the Subscriber does not enroll themselves and/or their Dependents when first eligible or during a Special Enrollment period, they will not be eligible to enroll until the next Open Enrollment Period.

Members Covered Under the Employer's Prior Plan

Members who were previously enrolled under another plan offered by the Employer that is being replaced by this Plan are eligible for coverage on the Effective Date of this coverage.

Enrolling Dependent Children

Newborn Children

Newborn children are covered automatically from the moment of birth. Following the birth a child, you should submit an application / change form to the Employer within 31 days to add the newborn to your Plan.

Even if no additional Fees are required, you should still submit an application / change form to the Employer to add the newborn to your Plan, to make sure we have accurate records and are able to cover your claims.

If additional Fees are required, your newborn's coverage will only continue past the initial 31 days if you send the Employer the application / change form and pay the additional Fees within 31 days of the birth.

Adopted Children

A child will be considered adopted from the earlier of: (1) the moment of placement in your home; or (2) the date of an entry of an order granting custody of the child to you. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption.

Your Dependent's Effective Date will be the date of the adoption or placement for adoption if you send the Employer the completed application / change form within 31 days of the event.

Adding a Child due to Award of Legal Custody or Guardianship

If you or your spouse is awarded legal custody or guardianship for a child, an application must be submitted within 31 days of the date legal custody or guardianship is awarded by the court. Coverage will be effective on the date the court granted legal custody or guardianship.

Qualified Medical Child Support Order

If you are required by a qualified medical child support order or court order, as defined by ERISA and/or applicable state or federal law, to enroll your child in this Plan, we will permit the child to enroll at any time without regard to any Open Enrollment limits and will provide the benefits of this Plan according to the applicable requirements of such order.

We will cover your child under this Plan once we get the application from you, the child's other parent, the Cabinet for Health and Family Services.

After the child is covered, and as long as you are eligible under this Plan, we will continue to cover the child unless we get satisfactory written evidence that the court order is no longer in effect or that the child has coverage under another health plan that provides comparable health coverage.

A child's coverage will not extend beyond any Dependent Age Limit listed in the Schedule of Benefits.

Updating Coverage and/or Removing Dependents

You are required to notify the Employer of any changes that affect your eligibility or the eligibility of your Dependents for this Plan. When any of the following occurs, contact the Employer and complete the appropriate forms:

- Changes in address;
- Marriage or divorce;
- Death of an enrolled family member (a different type of coverage may be necessary);
- Enrollment in another health plan or in Medicare;
- Eligibility for Medicare;
- Dependent child reaching the Dependent Age Limit (see "Termination and Continuation of Coverage");
- Enrolled Dependent child either becomes totally or permanently disabled, or is no longer disabled.

Failure to notify the Employer of individuals no longer eligible for services will not obligate the Plan to cover such services, even if Fees are received for those individuals. All notifications must be in writing and on approved forms. We will return any unearned Fees as required by Kentucky law.

Nondiscrimination

No person who is eligible to enroll will be refused enrollment based on health status, health care needs, genetic information, previous medical information, disability, sexual orientation or identity, gender, or age.

Statements and Forms

All Members must complete and submit applications or other forms or statements that the Employer may reasonably request.

Any rights to benefits under this Plan are subject to the condition that all such information is true, correct, and complete. Any material misrepresentation by you may result in termination of coverage as provided in the "Termination and Continuation of Coverage" section. The Plan will not use a statement made by you to void your coverage after that coverage has been in effect for two years. This does not apply, however, to fraudulent misstatements.

Termination and Continuation of Coverage

Termination

Except as otherwise provided, your coverage may terminate in the following situations:

- When the Administrative Services Agreement between the Employer and us terminates. If your coverage is through an association, your coverage will terminate when the Administrative Services Agreement between the association and us terminates, or when your Employer leaves the association. It will be the Employer's responsibility to notify you of the termination of coverage.
- If you choose to terminate your coverage.
- If you or your Dependents cease to meet the eligibility requirements of the Plan, subject to any applicable continuation requirements. If you cease to be eligible, you must notify the Employer immediately. You shall be responsible for payment for any services incurred by you after you cease to meet eligibility requirements.
- If you elect coverage under another carrier's health benefit plan, which is offered by the Employer as an option instead of this Plan, subject to the consent of the Employer. The Employer agrees to immediately notify us that you have elected coverage elsewhere.
- If you perform an act, practice, or omission that constitutes fraud or make an intentional misrepresentation of material fact, as prohibited by the terms of your Plan, your coverage and the coverage of your Dependents can be retroactively terminated or rescinded. A rescission of coverage means that the coverage may be legally voided back to the start of your coverage under the Plan, just as if you never had coverage under the Plan. You will be provided with a 30 calendar day advance notice with appeal rights before your coverage is retroactively terminated or rescinded. You are responsible for paying us for the cost of previously received services based on the Maximum Allowed Amount for such services, less any Copayments made or Fees paid for such services.
- If you fail to pay or fail to make satisfactory arrangements to pay your portion of the Fees, the Employer may terminate your coverage and may also terminate the coverage of your Dependents.
- If you permit the use of your or any other Member's Plan Identification Card by any other person; use another person's Identification Card; or use an invalid Identification Card to obtain services, your coverage will terminate immediately. Anyone involved in the misuse of a Plan Identification Card will be liable to and must reimburse the Plan for the Maximum Allowed Amount for services received through such misuse.
- If the Subscriber moves outside of the Service Area and the Subscriber's place of employment is not located within the Service Area.

You will be notified in writing of the date your coverage ends by either us or the Employer.

Removal of Members

Upon written request through the Employer, you may cancel your coverage and/or your Dependent's coverage from the Plan. If this happens, no benefits will be provided for Covered Services after the termination date.

Continuation of Coverage Under Federal Law (COBRA)

The following applies if you are covered by an Employer that is subject to the requirements of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended.

COBRA continuation coverage can become available to you when you would otherwise lose coverage under your Employer's health Plan. It can also become available to other Members of your family, who are covered under the Employer's health Plan, when they would otherwise lose their health coverage. For additional information about your rights and duties under federal law, you should contact the Employer.

Qualifying events for Continuation Coverage under Federal Law (COBRA)

COBRA continuation coverage is available when your coverage would otherwise end because of certain "qualifying events." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your Dependent children could become qualified beneficiaries if you were covered on the day before the qualifying event and your coverage would be lost because of the qualifying event. Qualified beneficiaries who elect COBRA must pay for this COBRA continuation coverage.

This benefit entitles each Member of your family who is enrolled in the Plan to elect continuation independently. Each qualified beneficiary has the right to make independent benefit elections at the time of annual enrollment. Covered Subscribers may elect COBRA continuation coverage on behalf of their spouses, and parents or legal guardians may elect COBRA continuation coverage on behalf of their children. A child born to, or placed for adoption with, a covered Subscriber during the period of continuation coverage is also eligible for election of continuation coverage.

Qualifying Event	Length of Availability of Coverage
<p><u>For Subscribers:</u></p> <p>Voluntary or Involuntary Termination (other than gross misconduct) or Loss of Coverage Under an Employer's Health Plan Due to Reduction In Hours Worked</p>	18 months
<p><u>For Dependents:</u></p> <p>A Covered Subscriber's Voluntary or Involuntary Termination (other than gross misconduct) or Loss of Coverage Under an Employer's Health Plan Due to Reduction In Hours Worked</p> <p>Covered Subscriber's Entitlement to Medicare</p> <p>Divorce or Legal Separation</p> <p>Death of a Covered Subscriber</p>	<p>18 months</p> <p>36 months</p> <p>36 months</p> <p>36 months</p>
<p><u>For Dependent Children:</u></p> <p>Loss of Dependent Child Status</p>	36 months

COBRA coverage will end before the end of the maximum continuation period listed above if you become entitled to Medicare benefits. In that case a qualified beneficiary – other than the Medicare beneficiary – is entitled to continuation coverage for no more than a total of 36 months. (For example, if you become entitled to Medicare prior to termination of employment or reduction in hours, COBRA continuation coverage for your spouse and children can last up to 36 months after the date of Medicare entitlement.)

If Your Employer Offers Retirement Coverage

If you are a retiree under this Plan, filing a proceeding in bankruptcy under Title 11 of the United States Code may be a qualifying event. If a proceeding in bankruptcy is filed with respect to your Employer, and that bankruptcy results in the loss of coverage, you will become a qualified beneficiary with respect to the bankruptcy. Your Dependents will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under this Plan. If COBRA coverage becomes available to a retiree and his or her covered family members as a result of a bankruptcy filing, the retiree may continue coverage for life and his or her Dependents may also continue coverage for a maximum of up to 36 months following the date of the retiree's death.

Second qualifying event

If your family has another qualifying event (such as a legal separation, divorce, etc.) during the initial 18 months of COBRA continuation coverage, your Dependents can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months from the original qualifying event. Such additional coverage is only available if the second qualifying event would have caused your Dependents to lose coverage under the Plan had the first qualifying event not occurred.

Notification Requirements

The Employer will offer COBRA continuation coverage to qualified beneficiaries only after the Employer has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Subscriber, commencement of a proceeding in bankruptcy with respect to the employer, or the Subscriber's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer will notify the COBRA Administrator (e.g., Human Resources or their external vendor) of the qualifying event.

You Must Give Notice of Some Qualifying Events

For other qualifying events (e.g., divorce or legal separation of the Subscriber and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Employer within 60 days after the qualifying event occurs.

Electing COBRA Continuation Coverage

To continue your coverage, you or an eligible family Member must make an election within 60 days of the date your coverage would otherwise end, or the date the company's benefit Plan Administrator notifies you or your family Member of this right, whichever is later. You must pay the total Fees appropriate for the type of benefit coverage you choose to continue. If the Fee rate changes for active associates, your monthly Fee will also change. The Fee you must pay cannot be more than 102% of the Fee charged for Employees with similar coverage, and it must be paid to the company's benefit plan administrator within 30 days of the date due, except that the initial Fee payment must be made before 45 days after the initial election for continuation coverage, or your continuation rights will be forfeited.

Disability extension of 18-month period of continuation coverage

For Subscribers who are determined, at the time of the qualifying event, to be disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act, and Subscribers who become disabled during the first 60 days of COBRA continuation coverage, coverage may continue from 18 to 29 months. These Subscribers' Dependents are also eligible for the 18- to 29-month disability extension. (This also applies

if any covered family Member is found to be disabled.) This would only apply if the qualified beneficiary gives notice of disability status within 60 days of the disabling determination. In these cases, the Employer can charge 150% of Fees for months 19 through 29. This would allow health coverage to be provided in the period between the end of 18 months and the time that Medicare begins coverage for the disabled at 29 months. (If a qualified beneficiary is determined by the Social Security Administration to no longer be disabled, such qualified beneficiary must notify the Plan Administrator of that fact in writing within 30 days after the Social Security Administration's determination.)

Trade Adjustment Act Eligible Individual

If you don't initially elect COBRA coverage and later become eligible for trade adjustment assistance under the U.S. Trade Act of 1974 due to the same event which caused you to be eligible initially for COBRA coverage under this Plan, you will be entitled to another 60-day period in which to elect COBRA coverage. This second 60-day period will commence on the first day of the month on which you become eligible for trade adjustment assistance. COBRA coverage elected during this second election period will be effective on the first day of the election period.

When COBRA Coverage Ends

COBRA benefits are available without proof of insurability and coverage will end on the earliest of the following:

- A covered individual reaches the end of the maximum coverage period;
- A covered individual fails to pay a required Fee on time;
- A covered individual becomes covered under any other group health plan after electing COBRA. If the other group health plan contains any exclusion or limitation on a pre-existing condition that applies to you, you may continue COBRA coverage only until these limitations cease;
- A covered individual becomes entitled to Medicare after electing COBRA; or
- The Employer terminates all of its group welfare benefit plans.

Other Coverage Options Besides COBRA Continuation Coverage

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions

Questions concerning your Employer's health Plan and your COBRA continuation coverage rights should be addressed to the Employer. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Continuation of Coverage Due To Military Service

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Subscriber or his / her Dependents may have a right to continue health care coverage under the Plan if the Subscriber must take a leave of absence from work due to military leave.

Employers must give a cumulative total of five years and in certain instances more than five years, of military leave.

“Military service” means performance of duty on a voluntary or involuntary basis and includes active duty, active duty for training, initial active duty for training, inactive duty training, and full-time National Guard duty.

During a military leave covered by USERRA, the law requires employers to continue to give coverage under this Plan to its Members. The coverage provided must be identical to the coverage provided to similarly situated, active employees and Dependents. This means that if the coverage for similarly situated, active employees and Dependents is modified, coverage for you (the individual on military leave) will be modified.

You may elect to continue to cover yourself and your eligible Dependents by notifying your employer in advance and submitting payment of any required contribution for health coverage. This may include the amount the employer normally pays on your behalf. If your military service is for a period of time less than 31 days, you may not be required to pay more than the active Member contribution, if any, for continuation of health coverage. For military leaves of 31 days or more, you may be required to pay up to 102% of the full cost of coverage, i.e., the employee and employer share.

The amount of time you continue coverage due to USERRA will reduce the amount of time you will be eligible to continue coverage under COBRA.

Maximum Period of Coverage During a Military Leave

Continued coverage under USERRA will end on the earlier of the following events:

1. The date you fail to return to work with the Employer following completion of your military leave. Subscribers must return to work within:
 - a) The first full business day after completing military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service.
 - b) 14 days after completing military service for leaves of 31 to 180 days,
 - c) 90 days after completing military service for leaves of more than 180 days; or
2. 24 months from the date your leave began.

Reinstatement of Coverage Following a Military Leave

Regardless of whether you continue coverage during your military leave, if you return to work your health coverage and that of your eligible Dependents will be reinstated under this Plan if you return within:

1. The first full business day of completing your military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service;
2. 14 days of completing your military service for leaves of 31 to 180 days; or
3. 90 days of completing your military service for leaves of more than 180 days.

If, due to an illness or injury caused or aggravated by your military service, you cannot return to work within the time frames stated above, you may take up to:

1. Two years; or
2. As soon as reasonably possible if, for reasons beyond your control you cannot return within two years because you are recovering from such illness or injury.

If your coverage under the Plan is reinstated, all terms and conditions of the Plan will apply to the extent that they would have applied if you had not taken military leave and your coverage had been continuous. Any waiting / probationary periods will apply only to the extent that they applied before.

Please note that, regardless of the continuation and/or reinstatement provisions listed above, this Plan will not cover services for any illness or injury caused or aggravated by your military service, as indicated in the "What's Not Covered" section.

Family and Medical Leave Act of 1993

A Subscriber who takes a leave of absence under the Family and Medical Leave Act of 1993 (the Act) will still be eligible for this Plan during their leave. We will not consider the Subscriber and his or her Dependents ineligible because the Subscriber is not at work.

If the Subscriber ends their coverage during the leave, the Subscriber and any Dependents who were covered immediately before the leave may be added back to the Plan when the Subscriber returns to work without medical underwriting. To be added back to the Plan, the Employer may have to give us evidence that the Family and Medical Leave Act applied to the Subscriber. We may require a copy of the health care Provider statement allowed by the Act.

General Provisions

Care Coordination

Anthem, as the Claims Administrator, pays In-Network Providers in various ways to provide Covered Services to you. For example, sometimes Anthem may pay In-Network Providers a separate amount for each Covered Service they provide. Anthem may also pay them one amount for all Covered Services related to treatment of a medical condition. Other times, Anthem may pay a periodic, fixed pre-determined amount to cover the costs of Covered Services. In addition, Anthem may pay In-Network Providers financial incentives or other amounts to help improve quality of care and/or promote the delivery of health care services in a cost-efficient manner, or compensate In-Network Providers for coordination of Member care. In some instances, In-Network Providers may be required to make payment to Anthem because they did not meet certain standards. You do not share in any payments made by In-Network Providers to Anthem under these programs.

Circumstances Beyond the Control of the Plan

If circumstances arise that are beyond the control of the Plan, we will make a good-faith effort to ensure Covered Services are available to you. Circumstances that may occur, but are not within the control of the Plan, include but are not limited to, a major disaster, epidemic, war, when health care services covered under this Plan are delayed or rendered impractical, or other events beyond our control. Under such circumstances, we will not be responsible for any delay or failure to give services due to lack of available Facilities or staff.

Clerical Error

A clerical error will never disturb or affect your coverage, as long as your coverage is valid under the rules of the Plan. This rule applies to any clerical error, regardless of whether it was the fault of the Employer or us.

Confidentiality and Release of Information

Applicable state and federal law requires us to undertake efforts to safeguard your medical information.

For informational purposes only, please be advised that a statement describing our policies and procedures regarding the protection, use and disclosure of your medical information is available on our website and can be furnished to you upon request by contacting our Member Services department.

Obligations that arise under state and federal law and policies and procedures relating to privacy that are referenced but not included in this Booklet are not part of the contract between the parties and do not give rise to contractual obligations.

Conformity with Law

Any term of the Plan which is in conflict with federal law will hereby be automatically amended to conform with the minimum requirements of such laws.

Contract with Anthem

The Employer, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Plan constitutes a Contract solely between the Employer and us, Anthem Health Plans of Kentucky, Inc., dba Anthem Blue Cross and Blue Shield (Anthem), and that we are an independent

corporation licensed to use the Blue Cross and Blue Shield names and marks in the state of Kentucky. The Blue Cross Blue Shield marks are registered by the Blue Cross and Blue Shield Association, an association of independently licensed Blue Cross and Blue Shield plans, with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries. Further, we are not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield plan or licensee. The Employer, on behalf of itself and its participants, further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than Anthem Health Plans of Kentucky, Inc. and that no person, entity, or organization other than Anthem shall be held accountable or liable to the Employer for any of Anthem's obligations to the Employer created under the Contract. This paragraph shall not create any additional obligations whatsoever on our part other than those obligations created under other terms of this agreement.

Form or Content of Booklet

No agent or employee of ours is authorized to change the form or content of this Booklet. Changes can only be made through a written authorization, signed by an officer of the Employer.

Government Programs

The benefits under this Plan shall not duplicate any benefits that you are entitled to, or eligible for, under any other governmental program. This does not apply if any particular laws require us to be the primary payer. If the Plan has duplicated such benefits, all money paid by such programs to you for services you have or are receiving, shall be returned by or on your behalf to the Plan.

Medical Policy and Technology Assessment

Anthem reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental / Investigational status or Medical Necessity of new technology. Guidance and external validation of Anthem's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Doctors from various medical specialties including Anthem's medical directors, Doctors in academic medicine and Doctors in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.

Medicare

Any benefits covered under both this Plan and Medicare will be covered according to Medicare Secondary Payer legislation, regulations, and Centers for Medicare & Medicaid Services guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, Booklet terms, and federal law.

Except when federal law requires the Plan to be the primary payer, the benefits under this Plan for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Part B. Where Medicare is the responsible payer, all sums payable by Medicare for services provided to you shall be reimbursed by or on your behalf to the Plan, to the extent the Plan has made payment for such services. If you do not enroll in Medicare Part B when you are eligible, you may have large out-of-pocket costs. Please refer to [Medicare.gov](http://www.Medicare.gov) for more details on when you should enroll, and when you are allowed to delay enrollment without penalties.

Member Rights and Responsibilities

The delivery of quality healthcare requires cooperation between patients, their Providers and their healthcare benefit plans. One of the first steps is for patients and Providers to understand Member rights and responsibilities. Therefore, Anthem Blue Cross and Blue Shield has adopted a members' Rights and Responsibilities statement.

It can be found on our website FAQs. To access, go to anthem.com and select member Support. Under the Support column, select FAQs and your state, then the "Laws and Rights That Protect You" category. Then click on the "What are my rights as a member?" question. Members or Providers who do not have access to the website can request copies by contacting Anthem, or by calling the number on the back of the Member ID card.

Modifications

The Plan Sponsor may change the benefits described in this Benefit Booklet and the Member will be informed of such changes as required by law. This Benefit Booklet shall be subject to amendment, modification, and termination in accordance with any of its provisions by the Employer, or by mutual agreement between the Claims Administrator and the Employer without the consent or concurrence of any Member. By electing medical and Hospital benefits under the Plan or accepting the Plan benefits, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all terms, conditions, and provisions hereof.

Not Liable for Provider Acts or Omissions

The Plan is not responsible for the actual care you receive from any person. This Booklet does not give anyone any claim, right, or cause of action against Anthem or the Plan based on the actions of a Provider of health care, services, or supplies.

Payment Innovation Programs

We, on behalf of the Employer, pay In-Network Providers through various types of contractual arrangements. Some of these arrangements – Payment Innovation Programs (Program(s)) – may include financial incentives to help improve quality of care and promote the delivery of health care services in a cost-efficient manner.

These Programs may vary in methodology and subject area of focus and may be modified by us from time to time, but they will be generally designed to tie a certain portion of an In-Network Provider's total compensation to pre-defined quality, cost, efficiency or service standards or metrics. In some instances, In-Network Providers may be required to make payment to us under the Program as a consequence of failing to meet these pre-defined standards.

The Programs are not intended to affect your access to health care. The Program payments are not made as payment for specific Covered Services provided to you, but instead, are based on the In-Network Provider's achievement of these pre-defined standards. You are not responsible for any Copayment or Coinsurance amounts related to payments made by us or to us under the Program(s), and you do not share in any payments made by Network Providers to us under the Program(s).

Policies, Procedures, and Pilot Programs

We, on behalf of the Employer, are able to introduce new policies, procedures, rules and interpretations, as long as they are reasonable.

Under the terms of the Administrative Service Agreement with your Employer, we have the authority, in our discretion, to institute from time to time, pilot or test programs for disease management, care management, case management, clinical quality or wellness initiatives that may result in the payment of benefits not otherwise specified in this Booklet. We reserve the right to discontinue a pilot or test program at any time.

Program Incentives

We, on behalf of the Employer, may offer incentives from time to time, at our discretion, in order to introduce you to covered programs and services available under this Plan. The Plan may also offer, at our discretion, the ability for you to participate in certain voluntary health or condition-focused digital applications or use other technology based interactive tool, or receive educational information in order to help you stay engaged and motivated, manage your health, and assist in your overall health and well-being. The purpose of these programs and incentives include, but are not limited to, making you aware of cost effective benefit options or services, helping you achieve your best health, and encouraging you to update member-related information. These incentives may be offered in various forms such as retailer coupons, gift cards, health related merchandise, and discounts on fees or Member cost shares. Acceptance of these incentives is voluntary as long as Anthem offers the incentives program. Motivational rewards, awards or points for achieving certain milestones may be a feature of the program. We, on behalf of the Employer, may discontinue a program or an incentive for a particular covered program or service at any time. If you have any questions about whether receipt of an incentive or retailer coupon results in taxable income to you, we recommend that you consult your tax advisor.

Relationship of Parties (Employer-Member-Anthem)

The Employer is fiduciary agent of the Member. Our notice to the Employer will constitute effective notice to the Member. It is the Employer's duty to notify us of eligibility data in a timely manner. This Plan is not responsible for payment of Covered Services of Members if the Employer fails to provide us with timely notification of Member enrollments or terminations.

Relationship of Parties (Anthem and In-Network Providers)

The relationship between Anthem and In-Network Providers is an independent contractor relationship. In-Network Providers are not agents or employees of ours, nor is Anthem, or any employee of Anthem, an employee or agent of In-Network Providers.

Your health care Provider is solely responsible for all decisions regarding your care and treatment, regardless of whether such care and treatment is a Covered Service under this Plan. We shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by you while receiving care from any In-Network Provider or in any In-Network Provider's Facilities.

Your In-Network Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to the provision of services or referrals to other Providers, including In-Network Providers, Out-of-Network Providers, and disease management programs. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or us.

Employer's Sole Discretion

The Employer may, in its sole discretion, cover services and supplies not specifically covered by the Plan. This applies if the Employer, with advice from us (the Claims Administrator), determines such services and supplies are in lieu of more expensive services and supplies which would otherwise be required for the care and treatment of a Member.

Reservation of Discretionary Authority

We, as the Claims Administrator, shall have all the powers necessary or appropriate to enable us to carry out our duties in connection with the operation of the Plan and interpretation of the Benefit Booklet. This includes, without limitation, the power to construe the Administrative Services Agreement, to determine all questions arising under the Plan, to resolve Member Appeals and to make, establish and amend the rules, regulations and procedures with regard to the interpretation of the Benefit Booklet of the Plan. A specific limitation or exclusion will override more general benefit language. We have complete discretion to interpret the Benefit Booklet. Our determination may include, without limitation, determination of whether the services, treatment, or supplies are Medically Necessary, Experimental/Investigative, whether surgery is cosmetic, and whether charges are consistent with the Plan's Maximum Allowed Amount. A Member may utilize all applicable Appeals procedures.

Right of Recovery and Adjustment

Whenever payment has been made in error, the Plan will have the right to recover such payment from you or, if applicable, the Provider or otherwise make appropriate adjustment to claims. In most instances such recovery or adjustment activity shall be limited to the calendar year in which the error is discovered. Except in cases of fraud, we will only recover such payment from the Provider during the 24 months after the date we made the payment on a claim submitted by the Provider.

We, as the Claims Administrator, have oversight responsibility for compliance with Provider and vendor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider or vendor resulting from these audits if the return of the overpayment is not feasible. Additionally, we have established recovery and adjustment policies to determine which recoveries and adjustments are to be pursued, when to incur costs and expenses and settle or compromise recovery or adjustment amounts. We will not pursue recoveries for overpayments or adjustments for underpayments if the cost of the activity exceeds the overpayment or underpayment amount. The Claims Administrator reserves the right to deduct or offset, including cross plan offsetting on In-Network claims and on Out-Of-Network claims where the Out-Of-Network Provider agrees to cross plan offsetting, any amounts paid in error from any pending or future claim.

Unauthorized Use of Identification Card

If you permit your Identification Card to be used by someone else or if you use the card before coverage is in effect or after coverage has ended, you will be liable for payment of any expenses incurred resulting from the unauthorized use. Fraudulent misuse could also result in termination of the coverage.

Value-Added Programs

We may offer health or fitness related programs to the Plan's Members, through which Members may access discounted rates from certain vendors for products and services available to the general public. Products and services available under this program are not Covered Services under your Plan but are in addition to Plan benefits. As such, program features are not guaranteed under your health Plan and could be discontinued at any time. We do not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.

Value of Covered Services

For purposes of subrogation, reimbursement of excess benefits, or reimbursement under any Workers' Compensation or Employer Liability Law, the value of Covered Services shall be the amount the Plan paid for the Covered Services.

Voluntary Clinical Quality Programs

The Plan may offer additional opportunities to assist you in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that you have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage you to get certain care when you need it and are separate from Covered Services under your Plan. These programs are not guaranteed and could be discontinued at any time. The Plan will give you the choice and if you choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, you may receive incentives such as gift cards or retailer coupons, which the Plan encourages you to use for health and wellness related activities or items. Under other clinical quality programs, you may receive a home test kit that allows you to test for immediate results or collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may also be offered a home visit appointment to collect such specimens and complete biometric screenings. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit or the home visit. If you have any questions about whether receipt of a gift card or retailer coupon results in taxable income to you, we recommend that you consult your tax advisor.

Voluntary Wellness Incentive Programs

We may offer health or fitness related program options for purchase by your Employer to help you achieve your best health. These programs are not Covered Services under your Plan, but are separate components, which are not guaranteed under this Plan and could be discontinued at any time. If your Employer has selected one of these options to make available to all employees, you may receive incentives such as gift cards by participating in or completing such voluntary wellness promotion programs as health assessments, weight management or tobacco cessation coaching. Under other options an Employer may select, you may receive such incentives by achieving specified standards based on health factors under wellness programs that comply with applicable law. If you think you might be unable to meet the standard, you might qualify for an opportunity to earn the same reward by different means. You may contact us at the Member Services number on your ID card and we will work with you (and, if you wish, your Doctor) to find a wellness program with the same reward that is right for you in light of your health status. (If you receive a gift card as a wellness reward and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

Employer Waiver

No agent or other person, except an authorized officer of the Employer, is able to disregard any conditions or restrictions contained in this Booklet, to extend the amount of time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

Workers' Compensation

The benefits under this Plan are not designed to duplicate benefits that you are eligible for under Workers' Compensation Law. All money paid or owed by Workers' Compensation for services provided to you shall be paid back by, or on your behalf of to the Plan if it has made or makes payment for the services received. It is understood that coverage under this Plan does not replace or affect any Workers' Compensation coverage requirements.

Definitions

If a word or phrase in this Booklet has a special meaning, such as Medical Necessity or Experimental / Investigational, it will start with a capital letter, and be defined below. If you have questions on any of these definitions, please call Member Services at the number on the back of your Identification Card.

Accidental Injury

An unexpected Injury for which you need Covered Services while enrolled in this Plan. It does not include injuries that you get benefits for under any Workers' Compensation, Employer's liability or similar law.

Ambulatory Surgery Center

A facility licensed as an Ambulatory Surgery Center as required by law that satisfies our accreditation requirements and, for an In-Network Provider, is approved by us.

Administrative Services Agreement

The agreement between the Claims Administrator and the Employer regarding the administration of certain elements of the health care benefits of the Employer's Group Health Plan.

Authorized Service(s)

A Covered Service you get from an Out-of-Network Provider that we have agreed to cover at the In-Network level. You will have to pay any In-Network Deductible, Coinsurance, and/or Copayment(s) that apply, and may also have to pay the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge unless your claim is a Surprise Billing Claim. Please see "Claims Payment" section as well as the "Consolidated Appropriations Act of 2021 Notice" at the front of this Booklet for more details.

Benefit Period

The length of time the Plan will cover benefits for Covered Services. For Calendar Year plans, the Benefit Period starts on January 1st and ends on December 31st. For Plan Year plans, the Benefit Period starts on your Employer's effective or renewal date and lasts for 12 months. (See your Employer for details.) The Schedule of Benefits shows if your Plan's Benefit Period is a Calendar Year or a Plan Year. If your coverage ends before the end of the year, then your Benefit Period also ends.

Benefit Period Maximum

The most the Plan will cover for a Covered Service during a Benefit Period.

Biomarker

A characteristic that is measured and evaluated as an indicator of normal biologic processes, pathogenic processes, or pharmacologic responses to a specific therapeutic intervention, including but not limited to:

- 1) Known gene-drug interaction for medications being considered for use or already being administered; and
- 2) Gene mutations and protein expression.

Biomarker Testing

The analysis of a patient's tissue, blood, or other biospecimen for the presence of a biomarker, including not limited to single-analyte tests, multiplex panel tests and whole genome sequencing.

Booklet

This document (also called the Benefit Booklet), which describes the terms of your benefits while you are enrolled in the Plan.

Centers of Excellence (COE) Network

A network of health care facilities, which have been selected to give specific services to our Members based on their experience, outcomes, efficiency, and effectiveness. An In-Network Provider under this Plan is not necessarily a COE. To be a COE, the Provider must have signed a Center of Excellence Agreement with us.

Claims Administrator

The company the Employer chose to administer its health benefits. Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield was chosen to administer this Plan. The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Coinsurance

Your share of the cost for Covered Services, which is a percent of the Maximum Allowed Amount. You normally pay Coinsurance after you meet your Deductible. For example, if your Plan lists 20% Coinsurance on office visits, and the Maximum Allowed Amount is \$100, your Coinsurance would be \$20 after you meet the Deductible. The Plan would then cover the rest of the Maximum Allowed Amount. See the "Schedule of Benefits" for details. Your Coinsurance will not be reduced by any refunds, rebates, or any other form of negotiated post-payment adjustments.

Consolidated Appropriations Act of 2021

Please refer to the "Consolidated Appropriations Act of 2021 Notice" at the front of this Booklet for details.

Controlled Substances

Drugs and other substances that are considered controlled substances under the Controlled Substances Act (CSA) which are divided into five schedules.

Copayment

A fixed amount you pay toward a Covered Service. You normally have to pay the Copayment when you get health care. The amount can vary by the type of Covered Service you get. For example, you may have to pay a \$15 Copayment for an office visit, but a \$150 Copayment for Emergency Room Services. See the "Schedule of Benefits" for details. Your Copayment will be the lesser of the amount shown in the Schedule of Benefits or the Maximum Allowed Amount.

Covered Services

Health care services, supplies, or treatment described in this Booklet that are given to you by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or specifically included as a benefit under this Booklet.
- Within the scope of the Provider's license.
- Given while you are covered under the Plan.
- Not Experimental / Investigational, excluded, or limited by this Booklet, or by any amendment or rider to this Booklet.
- Approved by us before you get the service if prior authorization is needed.

A charge for a Covered Service will apply on the date the service, supply, or treatment was given to you.

The date for applying Deductible and other cost shares for an Inpatient stay is the date of you enter the Facility.

Covered Services do not include services or supplies not described in the Provider records.

Covered Transplant Procedure

Please see the “What’s Covered” section for details.

Custodial Care

Any type of care, including room and board, that (a) does not require the skills of professional or technical workers; (b) is not given to you or supervised by such workers or does not meet the rules for post-Hospital Skilled Nursing Facility care; (c) is given when you have already reached the greatest level of physical or mental health and are not likely to improve further.

Custodial Care includes any type of care meant to help you with activities of daily living that does not require the skill of trained medical or paramedical workers. Examples of Custodial Care include:

- Help in walking, getting in and out of bed, bathing, dressing, eating, or using the toilet,
- Changing dressings of non-infected wounds, after surgery or chronic conditions,
- Preparing meals and/or special diets,
- Feeding by utensil, tube, or gastrostomy,
- Common skin and nail care,
- Supervising medicine that you can take yourself,
- Catheter care, general colostomy or ileostomy care,
- Routine services which we decide can be safely done by you or a non-medical person without the help of trained medical and paramedical workers,
- Residential care and adult day care,
- Protective and supportive care, including education,
- Rest and convalescent care.

Care can be Custodial even if it is recommended by a professional or performed in a Facility, such as a Hospital or Skilled Nursing Facility, or at home.

Deductible

The amount you must pay for Covered Services before benefits begin under this Plan. For example, if your Deductible is \$1,000, your Plan won’t cover anything until you meet the \$1,000 Deductible. The Deductible may not apply to all Covered Services. Please see the “Schedule of Benefits” for details.

Dependent

A member of the Subscriber’s family who meets the rules listed in the “Eligibility and Enrollment – Adding Members” section and who has enrolled in the Plan.

Designated Pharmacy Provider

An In-Network Pharmacy that has executed a Designated Pharmacy Provider Agreement with us or an In-Network Provider that is designated to provide Prescription Drugs, including Specialty Drugs, to treat certain conditions.

Developmental Delay

The statistical variation, as defined by standardized, validated developmental screening tests, such as the Denver Developmental Screening Test, in reaching age-appropriate verbal/growth/motor skill developmental milestones when there is no apparent medical or psychological problem. It alone does not constitute an illness or an Injury.

Doctor

Please see the definition of "Physician."

Effective Date

The date your coverage begins under this Plan.

Emergency (Emergency Medical Condition)

Please see the "What's Covered" section.

Emergency Care

Please see the "What's Covered" section.

Employee

A person who is engaged in active employment with the Employer and is eligible for Plan coverage under the employment rules of the Employer. The Employee is also called the Subscriber.

Employer

An Employer who has allowed its Employees to participate in the Plan by acting as the Plan Sponsor or adopting the Plan as a participating Employer by executing a formal document that so provides. The Employer or other organization has an Administrative Services Agreement with the Claims Administrator to administer this Plan.

Enrollment Date

The first day you are covered under the Plan or, if the Plan imposes a waiting period, the first day of your waiting period.

Excluded Services (Exclusion)

Health care services your Plan doesn't cover.

Experimental or Investigational (Experimental / Investigational)

Please see the "What's Not Covered" section.

Facility

A facility including but not limited to, a Hospital, freestanding Ambulatory Surgery Center, Residential Treatment Center, or Skilled Nursing Facility, as defined in this Booklet. The Facility must be licensed, as required by law, satisfy our accreditation requirements, and for an In-Network Provider, be approved by us.

Fee(s)

The amount you must pay to be covered by this Plan.

Home Health Care Agency

A Provider licensed when required by law and, for an In-Network provider, approved by us, that:

1. Gives skilled nursing and other services on a visiting basis in your home; and
2. Supervises the delivery of services under a plan prescribed and approved in writing by the attending Doctor.

Hospice

A Provider that gives care to terminally ill patients and their families, either directly or on a consulting basis with the patient's Doctor. It must be licensed by the appropriate agency.

Hospital

A facility licensed as a Hospital as required by law that must satisfy our accreditation requirements and, for an In-Network provider, be approved by us. The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

1. Nursing care
2. Rest care
3. Convalescent care
4. Care of the aged
5. Custodial Care
6. Educational care
7. Subacute care

Identification Card (ID Card)

The card given to you that shows your Member identification, group numbers, and the plan you have.

In-Network Provider

A Provider that has a contract, either directly or indirectly, with us, or another organization, to give Covered Services to Members through negotiated payment arrangements. A Provider that is In-Network for one plan may not be In-Network for another. Please see "How to Find a Provider in the Network" in the section "How Your Plan Works" for more information on how to find an In-Network Provider for this Plan. The name of network for this Plan is listed on your ID card.

In-Network Transplant Provider

Please see the "What's Covered" section for details.

Inpatient

A Member who is treated as a registered bed patient in a Hospital and for whom a room and board charge is made.

Intensive Outpatient Program

Structured, multidisciplinary treatment for Mental Health and Substance Use Disorders that provides a combination of individual, group and family therapy to Members who require a type or frequency of treatment that is not available in a standard outpatient setting.

Late Enrollees

Subscribers or Dependents who enroll in the Plan after the initial enrollment period. A person will not be considered a Late Enrollee if he or she enrolls during a Special Enrollment period. Please see the "Eligibility and Enrollment – Adding Members" section for further details

Maximum Allowed Amount

The maximum payment that we will allow for Covered Services. For more information, see the "Claims Payment" section.

Medical Necessity (Medically Necessary)

An intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury that is determined by us to be:

- Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the Member's condition, illness, disease or injury;
- Obtained from a Provider;
- Provided in accordance with applicable medical and/or professional standards;
- Known to be effective, as proven by scientific evidence, in materially improving health outcomes;
- The most appropriate supply, setting or level of service that can safely be provided to the Member and which cannot be omitted consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained in a less comprehensive setting);
- Cost-effective compared to alternative interventions, including no intervention or the same intervention in an alternative setting. Cost effective does not always mean lowest cost. It does mean that as to the diagnosis or treatment of the Member's illness, injury or disease, the service is not more costly than an alternative service or sequence of services that is medically appropriate. For example, the Plan will not provide coverage for an Inpatient admission for surgery if the surgery could have been performed on an outpatient basis or an infusion or injection of a Specialty Drug provided in the outpatient department of a Hospital if the drug could be provided in a Physician's office or the home setting;
- Not Experimental / Investigational;
- Not primarily for the convenience of the Member, the Member's family or the Provider.
- Not otherwise subject to an Exclusion under this Plan.

The fact that a Provider may prescribe, order, recommend, or approve care, treatment, services or supplies does not, of itself, make such care, treatment, services or supplies Medically Necessary or a Covered Service and **does not** guarantee payment.

Member

People, including the Subscriber and his or her Dependents, who have met the eligibility rules, applied for coverage, and enrolled in the Plan. Members are called "you" and "your" in this Booklet.

Mental Health and Substance Use Disorder

A condition, that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance use disorder condition.

Open Enrollment

A period of time in which eligible people or their dependents can enroll without penalty after the initial enrollment. See the "Eligibility and Enrollment – Adding Members" section for more details.

Out-of-Network Provider

A Provider that does not have an agreement or contract with us, or our subcontractor(s) to give services to Members under this Plan.

Benefits are not available when you use Out-of-Network Providers, unless they are for Emergency Care or for services approved in advance by Anthem as an Authorized Service.

Out-of-Network Transplant Provider

Please see the “What’s Covered” section for details.

Out-of-Pocket Limit

The most you pay in Copayments, Deductibles, and Coinsurance during a Benefit Period for Covered Services. The Out-of-Pocket limit does *not* include amounts over the Maximum Allowed Amount, or charges for health care that your Plan doesn’t cover. Please see the “Schedule of Benefits” for details.

Partial Hospitalization Program

Structured, multidisciplinary treatment for Mental Health and Substance Use Disorders, including nursing care and active individual, group and family treatment for Members who require more care than is available in an Intensive Outpatient Program.

Pharmacy and Therapeutics (P&T) Process

A process to make clinically based recommendations that will help you access quality, low cost medicines within your Plan. The process includes health care professionals such as nurses, pharmacists, and Doctors. The committees of the National Pharmacy and Therapeutics Process meet regularly to talk about and find the clinical and financial value of medicines for our Members. This process first evaluates the clinical evidence of each product under review. The clinical review is then combined with an in-depth review of the market dynamics, Member impact and financial value to make choices for the formulary. Our programs may include, but are not limited to, Drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and Drug profiling initiatives.

Pharmacy Benefits Manager (PBM)

A Pharmacy benefits management company that manages Pharmacy benefits on Express Scripts behalf. Express Scripts PBM has a nationwide network of Retail Pharmacies, a Home Delivery Pharmacy, and clinical services that include Prescription Drug List management.

The management and other services the PBM provides include, but are not limited to: managing a network of Retail Pharmacies and operating a mail service Pharmacy. Express Scripts PBM, in consultation with Express Scripts, also provides services to promote and assist Members in the appropriate use of Pharmacy benefits, such as review for possible excessive use, proper dosage, drug interactions or drug/pregnancy concerns.

Physician (Doctor)

Includes the following when licensed by law:

- Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery,
- Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O.,
- Doctor of Chiropractic (D.C.), legally licensed to perform the duties of a chiropractor;
- Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and

- Doctor of Dental Medicine (D.D.M.), Doctor of Dental Surgery (D.D.S.), legally entitled to provide dental services.

Optometrists, Clinical Psychologists (PhD), and surgical chiropractors are also Providers when legally licensed and giving Covered Services within the scope of their licenses.

Plan

The arrangement chosen by the Plan Sponsor to fund and provide for delivery of the Employer's health benefits.

Plan Administrator

The person or entity named by the Plan Sponsor to manage the Plan and answer questions about Plan details. ***The Plan Administrator is not the Claims Administrator.***

Plan Sponsor

The legal entity that has adopted the Plan and has authority regarding its operation, amendment and termination. ***The Plan Sponsor is not the Claims Administrator.***

Precertification

Please see the section "Getting Approval for Benefits" for details.

Prescription Drug (Drug)

A substance, that under the Federal Food, Drug & Cosmetic Act, must bear a message on its original packing label that says, "Caution: Federal law prohibits dispensing without a prescription." This includes the following:

- 1) Compounded (combination) medications, when all of the ingredients are FDA-approved, require a prescription to dispense, and are not essentially the same as an FDA-approved product from a drug manufacturer.
- 2) Insulin, diabetic supplies, and syringes.

Primary Care Physician ("PCP")

A Physician who gives or directs health care services for you. The Physician may work in family practice, general practice, internal medicine, pediatrics, geriatrics or any other practice allowed by the Plan.

Primary Care Provider

A Physician, nurse practitioner, clinical nurse specialist, physician assistant, or any other Provider licensed by law and allowed under the Plan, who gives, directs, or helps you get a range of health care services.

Provider

A professional or Facility licensed when required by law that gives health care services within the scope of that license, must satisfy our accreditation requirements and, for In-Network Providers, be approved by us. Details on our accreditation requirements can be found at <https://www.anthem.com/provider/credentialing/>. This includes any Provider that state law says we must cover when they give you services that state law says we must cover. Providers that deliver Covered Services are described throughout this Booklet. If you have a question about a Provider not described in this Booklet please call the number on the back of your Identification Card.

Qualifying Payment Amount

The median Plan In-Network contract rate we pay In-Network Providers for the geographic area where the service is provided for the same or similar services.

Recognized Amount

For Surprise Billing Claims, the Recognized Amount is calculated as follows:

- For Air Ambulance services, the Recognized Amount is equal to the lesser of the Qualifying Payment Amount as determined under applicable law (generally, the median Plan In-Network contract rate we pay In-Network Providers for the geographic area where the service is provided for the same or similar services) or the amount billed by the Out-of-Network Air Ambulance service provider.

For all other Surprise Billing Claims, the Recognized Amount is the lesser of the Qualifying Payment Amount or the amount billed by the Out-of-Network Provider or Out-of-Network Facility; or the amount approved under an applicable All-Payer Model Agreement under section 1115A of the Social Security Act.

Recovery

Please see the “Subrogation and Reimbursement” section for details.

Residential Treatment Center / Facility:

An Inpatient Facility that provides multidisciplinary treatment for Mental Health and Substance Use Disorder conditions. The Facility must be licensed as a residential treatment center in the state in which it is located, satisfy our accreditation requirements, and be approved by us.

The term Residential Treatment Center/Facility does not include a Provider, or that part of a Provider, used mainly for:

1. Nursing care
2. Rest care
3. Convalescent care
4. Care of the aged
5. Custodial Care
6. Educational care

Retail Health Clinic

A Facility that gives limited basic health care services to Members on a “walk-in” basis. These clinics are often found in major pharmacies or retail stores. Medical services are typically given by Physician Assistants and Nurse Practitioners.

Service Area

The geographical area where you can get Covered Services from an In-Network Provider.

Skilled Nursing Facility

An Inpatient Facility that provides multidisciplinary treatment for convalescent and rehabilitative care. It must be licensed as a skilled nursing facility in the state in which it is located, satisfy our accreditation requirements, and be approved by us.

A Skilled Nursing Facility is not a place mainly for care of the aged, Custodial Care or domiciliary care, or a place for rest, educational, or similar services.

Special Enrollment

A period of time in which eligible people or their dependents can enroll after the initial enrollment, typically due to an event such as marriage, birth, adoption, etc. See the “Eligibility and Enrollment – Adding Members” section for more details.

Specialist (Specialty Care Physician \ Provider or SCP)

A Specialist is a Doctor who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-Physician Specialist is a Provider who has added training in a specific area of health care.

Specialty Drugs

Drugs that typically need close supervision and checking of their effect on the patient by a medical professional. These drugs often need special handling, such as temperature-controlled packaging and overnight delivery, and are often not available at retail pharmacies. They may be administered in many forms including, but not limited to, injectable, infused, oral and inhaled.

Subscriber

An employee of the Employer who is eligible for and has enrolled in the Plan.

Surprise Billing Claim

Please refer to the “Consolidated Appropriations Act of 2021 Notice” at the front of this Booklet for details.

Transplant Benefit Period

Please see the “What’s Covered” section for details.

Urgent Care Center

A licensed health care Facility that is separate from a Hospital and whose main purpose is giving immediate, short-term medical care, without an appointment, for urgent care.

Utilization Review

Evaluation of the necessity, quality, effectiveness, or efficiency of medical or behavioral health services, Prescription Drugs (as set forth in the section Prescription Drugs Administered by a Medical Provider), procedures, and/or facilities.

Get help in your language

Curious to know what all this says? We would be too. Here's the English version: You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the Member Services telephone number on the back of your ID card.

Spanish

Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Albanian

Keni të drejtën të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për ndihmë, telefononi numrin e shërbimeve për anëtarët, të shënuar në kartën tuaj ID. (TTY/TDD: 711)

Amharic

ይህንን መረጃ እና እገዛ በቋንቋዎ በነጻ እገዛ የማግኘት መብት አልዎት። ለእገዛ በመታወቂያዎ ላይ ያለውን የአባል አገልግሎቶች ቁጥር ይደውሉ።(TTY/TDD: 711)

Arabic

يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجاناً. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف (TTY/TDD الخاصة بك للمساعدة): 711.

Armenian

Դուք իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն՝ Ձեր ID քարտի վրա նշված համարով: (TTY/TDD: 711)

Bassa

M bédé dyí-bèdèin-dèò b'é m'ké b'ò n'jà ke kè gbo-kpá- kpá dyé dé m' bídí-wùdùùn b'ó pídyi. Dá mébà jè gbo-gmò Kpòè n'òbà n'jà n' D'yí-dyoìn-b'èè k'òe b'é m'ké gbo-kpá-kpá dyé. (TTY/TDD: 711)

Bengali

আপনার বিনামূল্যে এই তথ্য পাওয়ার ও আপনার ভাষায় সাহায্য করার অধিকার আছে। সাহায্যের জন্য আপনার আইডি কার্ডে থাকা সদস্য পরিষেবা নম্বরে কল করুন।(TTY/TDD: 711)

Burmese

ဤအချက်အလက်များနှင့် အကူအညီကို သင့်ဘာသာစကားဖြင့် အခမဲ့ ရပိုင်ခွင့် သင့်တွင်ရှိပါသည်။ အကူအညီ ရယူရန် သင့် ID ကဒ်ပေါ်ရှိ အဖွဲ့ဝင်အတွက် ဝန်ဆောင်မှုများ ဌာန၏ နံပါတ်သို့ ခေါ်ဆိုပါ။ (TTY/TDD: 711)

Chinese

您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

Dinka

Yin nəŋ yic ba ye lək nē yök ku bē yi kuony nē thöŋ yin jām ke cin wëu töu kē piiny. Cöl rän töŋ dē kəc kē luoi nē namba dën tö nē I.D kat du yic. (TTY/TDD: 711)

Dutch

U hebt het recht om deze informatie en hulp gratis in uw taal te krijgen. Bel het ledendienstnummer op uw ID-kaart voor ondersteuning. (TTY/TDD: 711)

Farsi

شما این حق را دارید که این اطلاعات و کمکها را به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به شماره مرکز خدمات اعضا که بر روی کارت شناساییتان درج شده است، تماس بگیرید. (TTY/TDD: 711)

French

Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. (TTY/TDD: 711)

German

Sie haben das Recht, diese Informationen und Unterstützung kostenlos in Ihrer Sprache zu erhalten. Rufen Sie die auf Ihrer ID-Karte angegebene Servicenummer für Mitglieder an, um Hilfe anzufordern. (TTY/TDD: 711)

Greek

Έχετε το δικαίωμα να λάβετε αυτές τις πληροφορίες και αυτήν τη βοήθεια στη γλώσσα σας δωρεάν. Καλέστε τον αριθμό του Τμήματος Υπηρεσιών Μέλους (Member Services) που αναγράφεται στην ταυτότητά σας (ID card) για βοήθεια. (TTY/TDD: 711)

Gujarati

તમે તમારી ભાષામાં મફતમાં આ માહિતી અને મદદ મેળવવાનો અધિકાર ધરાવો છો. મદદ માટે તમારા આઈડી કાર્ડ પરના મેમ્બર સર્વિસ નંબર પર કોલ કરો. (TTY/TDD: 711)

Haitian

Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY/TDD: 711)

Hindi

आपके पास यह जानकारी और मदद अपनी भाषा में मुफ्त में प्राप्त करने का अधिकार है। मदद के लिए अपने ID कार्ड पर सदस्य सेवाएँ नंबर पर कॉल करें। (TTY/TDD: 711)

Hmong

Koj muaj cai tau txais qhov lus qhia no thiab kev pab hais ua koj hom lus yam tsis xam tus nqi. Hu rau tus nab npawb xov tooj lis Cov Kev Pab Cuam Rau Tswv Cuab nyob rau ntawm koj daim ID txhawm rau thov kev pab. (TTY/TDD: 711)

Igbo

Ị nwere ikike ịnweta ozi a yana enyemaka n'asụsụ gị n'efu. Kpọọ nọmba Ọrụ Onye Otu dị na kaadị NJ gị maka enyemaka. (TTY/TDD: 711)

Ilokano

Addanka ti karbengan a maala iti daytoy nga impormasyon ken tulong para ti lengguahem nga awanan ti bayadna. Awagan ti numero ti Serbisyo para ti Kameng a masarakan ayan ti ID kard mo para ti tulong. (TTY/TDD: 711)

Indonesian

Anda berhak untuk mendapatkan informasi ini dan bantuan dalam bahasa Anda secara gratis. Hubungi nomor Layanan Anggota pada kartu ID Anda untuk mendapatkan bantuan. (TTY/TDD: 711)

Italian

Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (TTY/TDD: 711)

Japanese

この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

Khmer

អ្នកមានសិទ្ធិក្នុងការទទួលបានព័ត៌មាននេះ និងទទួលបានជំនួយជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ សូមហៅទូរស័ព្ទទៅលេខសេវាសមាជិកដែលមានលើប័ណ្ណ ID របស់អ្នកដើម្បីទទួលបានជំនួយ។ (TTY/TDD: 711)

Kirundi

Ufise uburenganzira bwo gufashwa mu rurimi rwawe ku buntu. Akura umunywanyi abikora Ikaratakarangamuntu yawe kugira ufashwe. (TTY/TDD: 711)

Korean

귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Lao

ທ່ານມີສິດໄດ້ຮັບຂໍ້ມູນນີ້ ແລະ ຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ.
ໂທຫາເບີໂທຂອງຝ່າຍບໍລິການສະມາຊິກທີ່ໃຫ້ໄວ້ໃນບັດປະຈຳຕົວຂອງທ່ານເພື່ອຂໍຄວາມຊ່ວຍເຫຼືອ
. (TTY/TDD: 711)

Navajo

Bee ná ahoot'í t'áá ni nizaad k'ehjí níká a'doowoł t'áá jíík'e. Naaltsos bee atah nílínígíí bee néého'dólzingo nanitinígíí béésh bee hane'í bikáá' áají' hodíílnih. Naaltsos bee atah nílínígíí bee néého'dólzingo nanitinígíí béésh bee hane'í bikáá' áají' hodíílnih.

Nepali

तपाईंले यो जानकारी तथा सहयोग आफ्नो भाषामा निःशुल्क प्राप्त गर्ने तपाईंको अधिकार हो।
सहायताको लागि तपाईंको ID कार्डमा दिइएको सदस्य सेवा नम्बरमा कल गर्नुहोस्। (TTY/TDD: 711)

Oromo

Odeeffanoo kana fi gargaarsa afaan keetiin kaffaltii malee argachuuf mirga qabda.
Gargaarsa argachuuf lakkoofsa bilbilaa tajaajila miseensaa (Member Services) waraqaa enyummaa kee irratti argamu irratti bilbili. (TTY/TDD: 711)

Pennsylvania Dutch

Du hoscht die Recht selle Information un Hilfe in dei Schprooch mitaus Koscht griege.
Ruf die Member Services Nummer uff dei ID Kaarte fer Hilfe aa. (TTY/TDD: 711)

Polish

Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

Portuguese-Europe

Tem o direito de receber gratuitamente estas informações e ajuda no seu idioma. Ligue para o número dos Serviços para Membros indicado no seu cartão de identificação para obter ajuda. (TTY/TDD: 711)

Punjabi

ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)।

Romanian

Aveți dreptul să obțineți aceste informații și asistență în limba dvs. în mod gratuit. Pentru asistență, apălați numărul departamentului de servicii destinate membrilor de pe cardul dvs. de identificare. (TTY/TDD: 711)

Russian

Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Samoan

E iai lou 'aia faaletulafono e maua nei faamatalaga ma se fesoasoani i lou lava gagana e aunoa ma se tologi. Vili le numera mo Sauniuniga mo lou Vaega o loo maua i lou pepa faailoa ID mo se fesoasoani. (TTY/TDD: 711)

Serbian

Imate pravo da dobijete sve informacije i pomoć na vašem jeziku, i to potpuno besplatno. Pozovite broj Centra za podršku članovima koji se nalazi na vašoj identifikacionoj kartici. (TTY/TDD: 711)

Tagalog

May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Thai

ท่านมีสิทธิขอรับบริการสอบถามข้อมูลและความช่วยเหลือในภาษาของท่านฟรี โทรไปที่หมายเลขฝ่ายบริการสมาชิกบนบัตรประจำตัวของท่านเพื่อขอความช่วยเหลือ (TTY/TDD: 711)

Ukrainian

Ви маєте право безкоштовно отримати інформацію та допомогу своєю рідною мовою. По допомогу звертайтеся за номером служби підтримки учасників програми страхування, указаним на вашій ідентифікаційній картці. (TTY/TDD: 711)

Urdu

آپ کو اپنی زبان میں مفت ان معلومات اور مدد کے حصول کا حق ہے۔ مدد کے لیے اپنے آئی ڈی کارڈ پر موجود نمبر TTY/TDD:711-سروس نمبر کو کال کریں۔)

Vietnamese

Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

Yiddish

רופט די מעמבער באדינונגען איר האט די רעכט צו באקומען דעם אינפארמאציע און הילפט אין אייער שפראך בחינם.
(TTY/TDD:711 נומער אויף אייער קארטל פאר הילף)

Yoruba

O ní ètọ́ láti gba ìwífún yíí kí o sì sẹ̀rànwọ́ ní èdè ẹ̀ lófẹ́ẹ́. Pe Nọmbà àwọ̀n ipèsè ọ̀mọ-ẹ̀gbé lórí káàdì idánimọ́ ẹ̀ fún ìrànwọ́. (TTY/TDD: 711)

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

University of Kentucky Prescription Drug Benefit Program

Summary Plan Description

Introduction
Definitions
Services and Benefits
Limits to Covered Prescription Drug Benefit
Excluded Prescription Drugs
Member Appeals Process
Contact Information
Termination of Coverage

INTRODUCTION

The Prescription Drug Benefit Program is available to UK employees, UK early retirees and dependents that are enrolled as plan participants in the UK-HMO, UK-PPO, UK-EPO, UK-RHP, UK-HDHP HSA Saver, or the UK-Indemnity Health Plan options. The prescription benefit is administered directly by the University instead of through the medical plans. Enrollment in the prescription drug benefit program is automatic with the Member's enrollment on any of the UK Health Plans. The Member will have a separate prescription drug benefit identification card from Express Scripts which must be presented to the pharmacist at the time of service. A twelve-digit ID number (not the social security number) is assigned to the plan member.

If the plan member has a covered spouse and/or dependent(s), this same twelve-digit ID is used for each respective plan participant, with a different three-digit suffix (i.e. plan member - "001", spouse/dependent - "002", etc.)

Prescription drug benefits are payable for covered prescription expenses incurred by the Member and the Member's covered dependents. Benefits are payable for such expenses for charges made by a participating pharmacy for each separate prescription, subject to the applicable co-payment or coinsurance as shown in the Schedule of Benefits.

Express Scripts is the pharmacy benefit manager.

How to fill your prescription:

- **At your local participating pharmacy:** You will be able to obtain your immediate need (30-day supply) prescriptions through Express Scripts national network of chain and independent retail pharmacies.
- **Through Express Scripts Mail Service Pharmacy:** You will be able to receive your chronic need medications (up to a 90-day supply) by mail service. Your medications will be delivered free of shipping costs within two weeks. You will be charged for overnight or two-day delivery when you request such service. You will be able to track these prescriptions on the Express Scripts Web site, and can reorder them by phone, mail or online (www.express-scripts.com).
- **Through UK retail pharmacies (including Kentucky Clinic Pharmacy, Chandler Retail Pharmacy, University Health Pharmacy, Good Samaritan Pharmacy, Turfland Pharmacy, Bluegrass Pharmacy, Fountain Court Pharmacy, The Apothecary, or UK Specialty Pharmacy):** You will be able to obtain both your immediate need (30-day supply) prescriptions AND your chronic need (up to 90-day supply) prescriptions at the UK retail pharmacies.

DEFINITIONS

Ancillary Charge: A charge in addition to the Co-payment / Coinsurance which the member is required to pay to a Participating Pharmacy for a covered Brand name Prescription Drug Product for which a Generic substitute is available. The Ancillary Charge is calculated as the difference between the Pharmacy Payment Rate for the Brand name Prescription Drug Product dispensed and the Maximum Allowable Cost (MAC) of the Generic substitute.

Average Wholesale Price (AWP): The standardized cost of a drug product, calculated by averaging the cost of an undiscounted drug product charged to a drug wholesaler by a pharmaceutical manufacturer. AWP is as shown in the Express Scripts drug price file and as generally determined by "Medispan".

Brand: A patent-protected Prescription Drug Product that is manufactured and marketed under a trademark, proprietary or non-proprietary name by a specific drug manufacturer. (When manufacturers create new medications, they apply for a patent. After the patent expires, the FDA may approve other manufacturers to produce generic equivalents of the drug.)

Chemical Equivalents: Multiple-source drug products containing essentially identical amounts of the same active ingredients, in equivalent dosage forms, and which meet existing FDA physical/chemical standards.

Coinsurance: The percentage of the eligible expense for each separate prescription order or refill of a covered drug when dispensed by a participating pharmacy. The percentage coinsurance is based on the Pharmacy Payment rate if the Member utilizes a Participating Pharmacy and the Pharmacy submits the claim to Express Scripts electronically. The Member is responsible for payment of the Coinsurance at the point of service. Coinsurance may also be known as a percentage Co-payment.

Compound Drug: A drug prepared by a pharmacist using a combination of drugs in which at least one agent is a legend drug. The final product is typically not commercially available in the strength and/or dosage form prescribed by the physician.

Co-pay (Co-payment): The amount to be paid by you toward the cost of each separate prescription order or refill of a covered drug when dispensed by a participating pharmacy. A "flat dollar" Co-pay is a fixed dollar amount paid by the member when the prescription is filled. The member's Co-payment for a covered drug at a Participating Pharmacy shall be the lesser of the applicable Co-payment or the pharmacy submitted usual and customary charge. The Member is responsible for payment of the Co-pay at the point of service. Coinsurance may also be known as a percentage Co-payment.

Dependents: The individuals (usually spouse and children) that are included in the primary cardholder's benefit coverage.

Dispense as Written (DAW): A physician directive not to substitute a product.

Express Scripts Accredo Program: a specialty pharmacy management program specializing in the provision of high-cost biotech and other injectable drugs.

Formulary: A formulary is a clinically-based drug list that contains FDA-approved brand-name and generic drugs. Formularies are developed based on clinical attributes, as well as cost-effectiveness of products. Members will get the greatest value from their prescription drug benefit when they receive generic or brand-name drugs that are on the formulary. A formulary may also be referred to as a preferred drug list.

DEFINITIONS (continued)

A copy of the University of Kentucky Formulary is on-line at <http://www.uky.edu/hr/benefits/more-great-benefits/uk-prescription-benefit-forms> or by calling University of Kentucky Employee Benefits.

Formulary Brand: A brand-name drug that is listed on your formulary. It may also be referred to as a preferred brand drug.

Formulary Drug: A drug that is listed on your formulary. It may also be referred to as a preferred drug.

Generic: A drug that is chemically equivalent to a brand drug for which the patent has expired. The color and shape of the drug may be different, but the active ingredients are the same. Generic medications are required to meet the same quality standards as brand drugs.

Investigational: Any drug, device, supply, treatment, procedure, facility, equipment or service that is being studied to determine if it should be used for patient care or if it is effective. Something that is Investigational is not recognized as effective medical practice. We reserve the sole right to determine what Investigational is. Approval by the Food and Drug Administration (FDA) does not mean that we approve the service or supply. Drugs classified as Treatment Investigational New Drugs by the FDA are Investigational. Devices with the FDA Investigational Device Exemption and any services involved in clinical trials are Investigational.

Legend Drugs: A drug that can be obtained only by prescription order and bears the label "Caution: federal law prohibits dispensing without a prescription."

List of Drugs: See Formulary.

Local Pharmacy: See Participating Pharmacy.

Maximum Allowable Cost (MAC list): A maximum reimbursement amount. It is a list of Prescription Drug Products covered at a Generic product price. The MAC list applies to certain generic drug prescription products, but it also applies (under certain conditions) to multi-source products depending upon the DAW code submitted with the claim. This list is distributed to Participating Pharmacies and is subject to periodic review and modification.

Mail Pharmacy: A pharmacy that provides long-term supplies of maintenance medications via mail. Members usually pay less for these medications than they would if obtained from a local participating pharmacy.

Mail Service Benefit: A benefit that allows members to order long-term supplies of maintenance medications via mail. Members usually pay less for these medications than they would if obtained from a local participating pharmacy.

Maintenance Medication: Prescription drugs, medicines or medications that are generally prescribed for treatment of long-term chronic sickness or bodily injuries, and, purchased from the pharmacy contracted by the Plan Manager to dispense drugs.

Member: An individual eligible for benefits under the Plan as determined by University of Kentucky Employee Benefits.

DEFINITIONS (continued)

Member-Submitted Claims: Paper claims submitted by a Member for Prescription orders or refills at a Participating Pharmacy when the claim is not processed on-line electronically by Express Scripts (e.g., when eligibility cannot be verified at the point of service); such claims are to be reimbursed based on the Member Payment rate, adjusted for Co-pay, Coinsurance and Ancillary Charges.

Multi-source Brand: A brand-name medication for which there is a chemically equivalent product available.

Non-Covered Drugs: Drugs excluded from coverage include but are not limited to: drugs which can be purchased without a written prescription (over the counter drugs), non-FDA approved and experimental (investigational) drugs, medications used exclusively for cosmetic purposes, medications used in the treatment of a non-covered diagnosis (benefit) such as weight loss, and sexual dysfunction. Replacement of lost or stolen medications is not covered.

Non-Participating Pharmacy: A pharmacy which has not entered into an agreement with the Plan Manager to participate as part of the Express Scripts Pharmacy Network.

Non-Formulary Brand: A brand-name drug that is not listed on your formulary. Also referred to as a non-preferred brand drug.

Non-Preferred Brand: Drugs found not to have a significant therapeutic advantage over the Preferred drug. Also referred to as a non-formulary brand drug.

Over-the-counter (OTC) drug: A drug product that does not require a Prescription Order under federal or state law.

Out-of-Network Coverage: Your pharmacy benefit program does not allow for out-of-network coverage.

Participating Pharmacy: A pharmacy that has contractually agreed to provide prescription drug products to eligible members of a prescription benefit plan. Members must purchase their prescription drugs from a participating pharmacy to receive the coverage provided by the prescription benefit. The pharmacy will accept as payment the Co-payment / Coinsurance amount to be paid by you and the amount of the benefit payment provided by the Plan.

Participant: any covered person, who is properly enrolled in the Plan.

Pharmacist: a person who is licensed to prepare, compound and dispense medication and who is practicing within the scope of his or her license.

Pharmacy and Therapeutics (P&T) Committee: An organized panel of physicians and pharmacists from varying practice specialties, who function as an advisory panel to the Express Scripts benefit programs regarding the safe and effective use of prescription medications.

Pharmacy Payment Rate: The payment a Participating Pharmacy is entitled to receive, including any dispensing fee, for a particular Prescription Drug Product dispensed to a Member according to the terms of the applicable pharmacy provider contract, when the claim is processed on-line electronically by Express Scripts (or, on an exception basis, a Participating Pharmacy is allowed to submit paper claims to Express Scripts).

DEFINITIONS (continued)

Plan Administrator: the University of Kentucky.

Plan Manager: see Prescription Benefit Manager.

Plan Year: A period of time beginning on the Plan anniversary date of any year and ending on the day before the same date of the succeeding year.

Preferred Brand Drug: A brand-name drug that is listed on your formulary. It is also referred to as a formulary brand drug.

Preferred Drug: A drug that is listed on your formulary. It is also referred to as a formulary drug.

Prescription: A direct order for the preparation and use of drug, medicine or medication. The drug, medicine or medication must be obtainable only by prescription. The order must be given verbally, in writing, or by e-script by a qualified practitioner (prescriber) to a pharmacist for the benefit of and use by a covered person. The prescription must include

- Name and address of the covered person for whom the prescription is intended
- Type and quantity of the drug, medicine or medication prescribed, and the directions for its use.
- Date the prescription was prescribed
- Name, address and license number of the prescribing qualified practitioner

Prescription Benefit Manager (PBM): Express Scripts. The PBM provides services to the Plan Administrator, as defined under the Plan Management Agreement. The Plan Manager is not the Plan Administrator.

Prescription Drug Product: A medication, product or device approved by the FDA and dispensed under federal or state law only pursuant to a Prescription Order or Refill. This definition also includes insulin and certain diabetic supplies if dispensed pursuant to a Prescription Order or Refill.

Prescription Order or Refill: The directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

Prior Authorization: The required prior approval from the Plan Manager for the coverage of prescription drugs, medicines, medications, including the dosage, quantity and duration, as appropriate for the covered person's age and sex. Certain prescription drugs, medicines or medications may require prior authorization.

Single-Source Brand: A brand medication for which there is no generic version available.

Therapeutic Equivalent: A medication that can be expected to have the same clinical effect and safety profile when administered under the conditions specified in labeling as another medication, although the medications are not Chemical Equivalents.

UK Retail Pharmacy: Retail pharmacies operated by UK Healthcare, including Chandler Retail Pharmacy, Good Samaritan Pharmacy, Kentucky Clinic Pharmacy, Turfland Clinic Pharmacy, University Health Pharmacy, UK Specialty Pharmacy, Bluegrass Clinic Pharmacy, Fountain Court Clinic Pharmacy, and The Apothecary.

Usual and Customary (U&C) Charge: The usual and customary price charged by a pharmacy for a Prescription Drug Product dispensed to a cash paying customers.

Prescription Benefit Program

SERVICES AND BENEFITS

Schedule of Benefits

	1-month supply local pharmacy co-insurance	1-month supply local pharmacy minimum	1-month supply local pharmacy maximum	3-month supply mail service or UK Retail Pharmacy co-insurance	3-month supply mail service or UK Retail Pharmacy minimum	3-month supply mail service or UK Retail Pharmacy maximum
Generic	20%	\$8.00	\$50.00	10%	\$24.00	\$100.00
Formulary Brand	40%	\$20.00	\$60.00	30%	\$60.00	\$120.00
Non-Formulary Brand	50%	\$40.00	No Maximum	40%	\$120.00	No Maximum
Specialty Generic <u>Limited to UK Specialty Pharmacy or Accredo Specialty Pharmacy Only</u>	20%	\$8.00	\$50.00	Limited to 30 day supply	Limited to 30 day supply	Limited to 30 day supply
Specialty Brand* <u>Limited to UK Specialty Pharmacy or Accredo Specialty Pharmacy Only</u>	\$200	NA	NA	Limited to 30 day supply	Limited to 30 day supply	Limited to 30 day supply

*Certain Specialty Medications are considered non-essential health benefits under the plan. Copays for these Specialty Medications will be set to the maximum of current plan design or any available manufacturer-funded copay assistance. Program drugs will be reimbursed by the manufacturer at no cost to the participant. The cost of such drugs will not be applied towards participants Rx out of pocket. List of included Specialty Medications available at <https://hr.uky.edu/forms/prescription>.

**Out of Pocket Adjustment – Specialty medications filled through Accredo that have a copay card applied will only report what the patient actually pays for the medication to the Out of Pocket accumulator. The amount that the drug manufacturer applies through copay assistance, coupons, or any other form will not count towards the patient's yearly maximum out of pocket accumulator.

Retail Prescription Program

Drugs that are prescribed for short-term use (up to a 34-day supply) should be filled using the retail drug card. The Retail Prescription Drug Card Program is administered by Express Scripts. Participants are provided a prescription drug card to purchase drugs from a local pharmacy that participates in the Express Scripts Network. This network includes over 53,000 pharmacies nationwide. These include most chain or grocery stores such as Wal-Mart or Meijer as well as many independent pharmacies across the nation. Confirmation of participating pharmacies may be obtained by calling Express Scripts at 1-877-242-1864 or through the web site at www.express-scripts.com.

The amount of the coinsurance or co-payment is dependent upon whether the prescription is for a generic, a formulary brand name drug or a non-formulary brand name drug. A generic drug is identical in chemical composition to its brand name counterpart, has been approved by the Food and Drug Administration to be

SERVICES AND BENEFITS (continued)

therapeutically equivalent, and is as effective as the brand name product. The use of generics and formulary brand name drugs help to keep the cost of prescription drugs down for both the participant and the plan. All non-formulary drugs have alternatives available; preferred brand name drugs and possibly generics, both of which are more, cost effective.

As a participant in this program, you must pay for:

- The cost of medication not covered under the prescription benefit;
- The cost of any quantity of medication dispensed in excess of a consecutive 30-day non-maintenance medication supply.

A copy of the University of Kentucky Formulary is on-line at <https://hr.uky.edu/forms/prescription> or by calling University of Kentucky Employee Benefits.

The Co-payments or Coinsurance for each type Retail (30-day) prescription at your local participating pharmacy are:

- Generic: 20% or minimum of \$8.00
- Formulary Brand Name Drug: 40% or minimum of \$20.00
- Non-Formulary Brand Name Drug: 50% or minimum of \$40.00

The out of pocket maximum is \$50 per generic prescription and \$60 for formulary brand name drugs (non-formulary drugs have no maximum). There is a mandatory generic program. If the Member or Physician does not accept the generic equivalent for a "brand name" drug when one exists, the Member will be responsible for the applicable brand name Co-pay or coinsurance, plus any cost difference between the brand name and generic drug up to the retail price of the requested drug. This ancillary cost difference does not apply toward

out-of-pocket maximum and will continue to apply after out-of-pocket maximum is met

Each retail prescription is limited to a 34-day supply. However if the medical condition is such that the prescription drug is to be taken over a prolonged period of time (month or even years) it may be more financially advantageous to use UK Retail Pharmacies or Express Scripts Mail Order.

Reimbursement for prescriptions purchased at non-network pharmacies will not be reimbursed under your prescription benefit, and are the financial responsibility of the Member. Purchases at non-network pharmacies do not apply to out-of-pocket maximum.

All paper claims incurred during the calendar year must be submitted within 365 days of the original date of service. Any claims received after that date will be denied.

Pharmacy benefit Co-payments and Coinsurance cannot be applied toward the deductibles or out-of-pocket limits of the medical plans (UK-HMO, UK-PPO, UK-EPO, UK-RHP, or UK-Indemnity). There is a separate prescription benefit out-of-pocket maximum of \$5,000 for single coverage and \$10,000 per family.

Mail Service Prescription Program

The mail order program is designed for individuals who take the same medication over a long period of time for conditions such as diabetes, high blood pressure, ulcers, emphysema, arthritis, heart or thyroid conditions. While it is not mandatory to use the mail order program, those that do may reduce their out of pocket payments and will not have to reorder as frequently.

Accept the generic equivalent for a "brand name" drug when one exists, the Member will be responsible for the applicable brand name Co-pay or Coinsurance, plus any cost difference between the brand name and generic drug up to the retail price of the requested drug. This ancillary cost difference does not apply toward out-of-pocket maximum and will continue to apply after out-of-pocket maximum is met

Each mail service prescription is limited to a maximum quantity limit of a 90-day supply. Express Scripts is required by law to dispense the prescription in the exact quantity specified by the physician. Therefore if the quantity prescribed is for less than 90 days per refill Express Scripts will fill that exact quantity.

Submitting New Prescriptions:

1. Complete a Mail Service Enrollment Order Form and submit to Express Scripts along with the original prescription(s). Order forms for the mail service prescription drug program are available from Express Scripts online, via telephone, or can be provided by the University of Kentucky HR Benefits office or from the Know Your Rx Coalition at 855-218-5979
2. Express Scripts or the Know Your Rx Coalition can contact your prescriber to have new prescription orders submitted to the Express Scripts Home Delivery Pharmacy
3. Your prescriber can submit a new prescription to Express Scripts Home Delivery via phone, fax, or through ePrescribing

MD Fax Rx line 800-837-0959

ePrescribing – Express Scripts, 4600 North Hanley Rd, St Louis, MO 63134 NCPDP 2623735

MD Telephone Verbal Orders 888-327-9791, option 2

Refills for maintenance medications through the mail order pharmacy can be obtained by phone at 1-877-242-1864, or through the Express Scripts web site at www.express-scripts.com.

UK Retail Pharmacies

UK Pharmacies also can mail prescriptions in the state of Kentucky to members in the UK health plan at no cost. In addition, prescriptions written by a UK physician and filled at a UK pharmacy are eligible for an additional discount. Utilizing UK Pharmacies for acute and maintenance 90-day prescriptions helps lower member out-of-pocket expenses significantly.

Procedure for Specialty Medications:

High-cost biotech and other injectable drugs used to treat long-term chronic disease states considered to be Specialty Medications are limited to being provided by the UK Specialty Pharmacy (859-218-5413) or Accredo Specialty Pharmacy. These medications include, but are not limited to, Pegasys, PEG-Intron, Avonex, Betaseron, Copaxone, Rebif, Humira, Enbrel, Neupogen, and Lovenox.

There are other medications which include Epclusa and Harvoni that are ONLY available thru Accredo Specialty pharmacy. Other specialty medications may be available thru limited distribution by pharmaceutical manufacturer to a specific specialty pharmacy.

There are other injectable medications that may be administered only by the physician. Coverage status of these medications as a pharmacy benefit versus medical benefit is subject to review and prior-approval by the Plan.

Covered Prescription Drugs

1. Covered prescription drugs, medicines or medications must
 - a. Be prescribed by a qualified practitioner for the treatment of a sickness or bodily injury;
 - b. Be dispensed by a pharmacist;
 - c. Require a prescription by federal law unless otherwise excluded.
2. Benefits are provided for Medically Necessary Prescription Drugs and medicines incidental to care of an Outpatient.
3. Compounded medications for which ALL ingredients are approved for coverage.
4. Injectable insulin when prescribed by a physician, including diabetic supplies (needles, syringes, test strips, lancets, pens).
5. Aerochambers, spacers, peak flow meters;
6. Self-administered injectable drugs labeled by the manufacturer as approved for self-administration limited to those approved by the Prescription Benefit, and available through the Participating Pharmacies or Express Scripts Accredo program;
7. Most routine vaccines are covered on Rx benefit (i.e. COVID, Tdap, Influenza, Hep A, Zoster, HPV, Penumococcal, RSV)
8. Oral contraceptives
9. Special Foods for Inborn Errors of Metabolism: Amino acid modified preparations and low-proteinmodified food products for the treatment of inherited metabolic diseases if the amino acid products are prescribed for the therapeutic treatment of inherited metabolic diseases and administered under the direction of a physician.
 - a. Coverage for amino acid modified preparations and infant formulas are subject, for each Plan Year, to a cap of twenty-five thousand dollars (\$25,000), and low-protein modified food products shall be subject, for each Plan Year, to a cap of four thousand (\$4,000), subject to annual inflation adjustments.
 - b. Covered services under this section for the following conditions: (1) Phenylketonuria; (2)

Hyperphenylalaninemia; (3) Tyrosinemia (types I, II and III); (4) Maple syrup urine disease; (5) A-ketoacid dehydrogenase deficiency; (6) Isovaleryl-CoA dehydrogenase deficiency; (7) 3-methylcrotonyl-CoA carboxylase deficiency; (8) 3-methylglutaconyl-CoA hydratase deficiency; (9) 3-hydroxy-3-methylglutaryl-CoA lyase deficiency (HMG-CoA lyase deficiency); (10) b-ketothiolase deficiency; (11) Homocystinuria; (12) Glutaric aciduria (types I and II); (13) Lysinuric protein intolerance; (14) Non-ketotic hyperglycinemia; (15) Propionic acidemia; (16) Gyrate atrophy; (17) Hyperornithinemia / hyperammonemia / homocitrullinuria syndrome; (18) Carbamoyl phosphate synthetase deficiency; (19) Ornithine carbamoyl transferase deficiency; (20) Citrullinemia; (21) Arginosuccinic aciduria; (22) Methylmalonic acidemia; and (23) Argininemia.

- c. The Member should use Participating Pharmacies for prescription products and special supplements. If the purchase of such foods is from a supplier who will not bill Express Scripts, the Member should submit the detailed receipt along with a copy of the prescription to University of Kentucky Employee Benefits Member Services for reimbursement.

Prescription Benefit Program

SERVICES AND BENEFITS (continued)

LIMITS TO COVERED PRESCRIPTION DRUG BENEFIT

1. The covered benefit for any one prescription will be limited to:
 - a. Quantities that can reasonably be expected to be consumed or used within 30 days or as otherwise authorized by the Plan;
 - b. Refills only up to the number specified by a physician;
 - c. Refills up to one year from the date of the initial prescription order.
2. Certain prescription drugs require prior-authorization in accordance to guidelines adopted by Express Scripts, including but not limited to: growth hormones, Epogen/Procrit, Enbrel, Humira, Prolastin, Lidoderm, Lovaza, Forteo, Regranex, and Aranesp. .
3. Inclusion of a particular medication on the Preferred Drug List is not a guarantee of coverage. The level of benefits received is based on your prescription drug benefit and the Preferred Drug List status of each drug at the time the prescription is filled. The Plan reserves the right to reassign drugs to a different level or non-formulary status at any time during the plan year. The Plan also reserves the right to change quantity limits or prior authorization status during the plan year.
4. Certain medical supplies and drugs may be separate from the Prescription Drug Benefit. Members may not obtain these items as pharmacy benefits using the Plan's prescription benefit. The supplier of these items must submit a claim directly to the member's UK health plan.

EXCLUDED PRESCRIPTION DRUGS

1. Over the counter products that may be purchased without a written prescription or their equivalents. This includes those drugs or medicines which become available without a prescription having previously required a prescription. This does not apply to injectable insulin, insulin syringes and needles and diabetic supplies, which are specifically included.
2. Over the Counter equivalents: As determined by the Prescription Benefit, these are selected prescription drugs (legend drugs) according to Medispan with OTC equivalent product(s) available.
 - a. These products have a similar OTC product which has an identical strength, an identical route of administration, identical active chemical ingredient(s), and an identical dosage form (exceptions may be made for similar oral liquid dosage forms); (e.g., Niferex-150, Lac-Hydrin, benzoyl peroxide products, Lamisil AT, Lotrimin AF).

- b. These products have a similar OTC product which has an identical systemic strength (for orally administered medications; or can achieve an identical systemic strength by using multiples of the OTC product reserved for select products), same route of administration, same active chemical ingredient (variations of salt forms included), and a similar dosage form. Topically administered legend products may not have the same strength (concentration) as their similar OTC equivalent, but will reside within or near a range of strengths available (lower strength legend products will be included in the exclusion if there are higher strength OTC products available) for similar OTC equivalent products (e.g., benzoyl peroxide products, lidocaine products).
3. Therapeutic devices or appliances, even though such devices may require a prescription including (but not limited to):
- a. Hypodermic needles, syringes, (except needles and syringes for diabetes);
 - b. Support garments;
 - c. Test reagents;
 - d. Mechanical pumps for delivery of medications and ancillary pump products;

EXCLUDED PRESCRIPTION DRUGS (continued)

- e. Implantable insulin pumps, insulin pump supplies;
 - f. Other non medical substances;
 - g. Durable medical equipment
 - h. Medical Foods
4. Injectable drugs, including but not limited to:
- a. Immunization agents;
 - b. Biological serum;
 - c. Blood or blood plasma; or
 - d. Self-administered medications not indicated in covered prescription drugs.
 - e. Injectable drugs intended for administration in a Provider's office or other medical facilities are NOT covered if purchased by a Member directly from a retail pharmacy.
5. Any oral drug or medicine or medication that is consumed or injected, at the place where the prescription is given, or dispensed by the qualified practitioner;
6. Contraceptive implants and IUDs
7. Implantable time-released medications or drug delivery implants.
8. Abortifacients (drugs used to induce abortions - refer to medical benefit for life threatening abortion coverage);
9. Experimental or investigational drugs or drugs prescribed for experimental, non-FDA approved, indications.
10. Any drug prescribed for intended use other than for:
- Indications approved by the FDA; or
 - Recognized off-label indications through peer-reviewed medical literature.
11. Compound chemical ingredients or combination of federal legend drugs in a non-FDA approved dosage form. Drugs, including compounded drugs, which are not FDA approved for treatment for a specified category of medical conditions, unless the Plan determines such use is consistent with standard medical practice and has been effective in published peer review medical literature as to leading to improvement in health outcomes. Compound Kits, including but not limited to First-omeprazole and First-Vancomycin,
12. Dietary supplements, nutritional products, or nutritional supplements except for hereditary metabolic

diseases only;

13. Herbs, minerals, fluoride supplements and vitamins, except prenatal (including greater than one milligram of folic acid) and pediatric multi-vitamins with fluoride;
14. Progesterone crystals or powder in any compounded dosage form; bioidentical hormones in any compounded dosage form
15. Allergen extracts;
16. Anabolic steroids;
17. Treatment for onychomycosis (nail fungus), except for immunocompromised or diabetic patients;
18. Medications used in the treatment of a non-covered diagnosis.
19. Any drug used for cosmetic purposes, including but not limited to:
 - Tretinoin (e.g., Retin A), except if you are under age 30 or are diagnosed as having adult acne;
 - Anti wrinkle agents or photo-aged skin products (e.g., Renova, Avage);
 - Dermatological or hair growth stimulants (e.g., Propecia, Vaniqa);
 - Pigmenting or de-pigmenting agents (e.g., Solaquin);
 - Injectable cosmetics (e.g., Botox)
20. Anorectic or any drug used for the purpose of weight reduction or weight control, suppress appetite or control fat absorption, including, but not limited to, Adderall, Dexedrine, Xenical.
21. Any drug prescribed for impotence and or sexual dysfunction, (e.g., Muse, Viagra, Cialis, Levitra, Caverject, Edex, Yohimbine).
22. For prescription drugs:
 - In a quantity which is in excess of a 34 day supply obtained at a retail pharmacy;
 - In a quantity which is in excess of a 90 day mail order supply;
 - In a quantity which is in excess of the amount prescribed;
23. Replacement of lost or stolen medications is not covered.
24. Drugs obtained at a non-participating provider pharmacy.
25. Any drug for which a charge is customarily not made, or for which the dispenser's charge is less than the co-payment amount in the absence of this benefit.
26. Prescriptions that are to be taken by or administered to the covered person, in whole or in part, while he or she is a Member in a facility where drugs are ordinarily provided by the facility on an inpatient basis, are not covered. Inpatient facilities include, but are not limited to:
 - Hospital;
 - Rest home;
 - Sanitarium;
 - Skilled nursing facility;
 - Convalescent hospital;
 - Hospice facility

EXCLUDED PRESCRIPTION DRUGS (continued)

Benefits are not provided for medication used by an Outpatient to maintain drug addiction or drug dependency, Methadone Maintenance Program or medications which are excessive or abusive for your condition or diagnosis.

The Plan Manager may decline coverage of a specific medication or, if applicable, drug list inclusion of any and all drugs, medicines or medications until the conclusion of a review period not to exceed six (6) months following FDA approval for the use and release of the drug, medicine or medication into the market.

Items that may be covered by state or federal programs, such as items covered by Worker's Compensation.

Expense incurred will not be payable for the following:

- Legend drugs which are not recommended and not deemed necessary by a prescriber;
- The administration of covered medication;
- Any drug, medicine or medication received by the covered person:
 - Before becoming covered under the Plan; or
 - After the date the covered person's coverage under the Plan has ended;
- Any drug, medicine or medication labeled "Caution - limited by Federal Law to investigational use" or any experimental drug, medicine or medication, even though a charge is made to the covered person;
- Any costs related to the mailing, sending or delivery of prescription drugs;
- Any fraudulent misuse of this benefit including prescriptions purchased for consumption by someone other than the covered person;
- Prescription or refill for drugs, medicines or medications that are lost, stolen, spilled, spoiled or damaged;
- More than one prescription for the same drug or therapeutic equivalent medication prescribed by one or more Qualified Practitioners and dispensed by one or more Pharmacies until at least 75% of the previous Prescription has been used by the Covered Person, unless the drug or therapeutic equivalent medication is dispensed at a mail order service in which case 66% of the previous Prescription must have been used by the covered person;
- Any drug or biological that has received an "orphan drug" designation, unless approved by the Plan;
 - Any Co-payment or Coinsurance you paid for a prescription that has been filled, regardless of whether the Prescription is revoked or changed due to adverse reaction or change in dosage or Prescription

UK PRESCRIPTION PLAN COMPLAINT AND GRIEVANCE PROCESS

There is a formal complaint and appeal process for handling Member concerns. A complaint is an oral or written expression of dissatisfaction. An appeal is a request to change a previous decision made by Express-Scripts for the Prescription Benefit. If a Covered Person has a problem or complaint regarding any aspect of the administration of benefits by UK Prescription Plan, the Member may contact the UK HR Benefits Office or Express Scripts Member Services to discuss the matter. If the matter cannot be resolved within a reasonable time to the Member's satisfaction, the Member may submit a written appeal. The UK Prescription plan provides a five-step appeal process to resolve Member concerns. The administrative remedies established by this appeal process must be satisfied before legal remedies are sought.

Step 1 - Informal Inquiry

We recommend that you always contact Express Scripts Member Services first when you have a problem, concern or complaint. The Member Services toll-free number is 1-877-242-1864 (or 1-800-972-4348 for

hearing-impaired). You may also write UK HR Prescription Benefits, 2365 Harrodsburg Rd. Ste 375, Lexington, KY 40504 or call the UK Pharmacy Benefits Office at 859-218-5979.

Inquiries should include a summary of the issue, provide a description of any previous contact(s) with the Plan regarding the matter in question, and describe the relief sought. Most inquiries are handled immediately. If further research is required, a representative will respond to you within 7 working days. If additional information from a Provider/Prescriber is required, the Plan may need additional time to respond to your concern through all phases of the appeal process. In such cases, the Plan will notify you of any delays.

Step 2 - Written Appeal

If your concern is not settled to your satisfaction at Step 1, you may appeal the decision within 45 days following the day of your first request for coverage by submitting a written statement of concern to:

UK Prescription Benefits
2365 Harrodsburg Rd, Ste 375
Lexington, KY 40504

The statement should include a summary of the complaint or issue, information regarding previous contact(s) with the plan regarding the matter in question and a description of the relief sought. Express Scripts Appeals Dept. will notify you of the decision within 30 days after receipt of the appeal.

Step 3 - Formal Grievance Hearing

If you are not satisfied with the outcome of your appeal, you may submit a written request for a hearing to the Prescription Plan Grievance Committee within 30 days after receipt of the appeal decision. The request should be directed to UK HR Benefits, Prescription Plan Appeals Coordinator, 2365 Harrodsburg Rd Ste 375, Lexington, KY 40504. The Grievance Committee will acknowledge your request within 7 working days and hear your case within 30 days. The Grievance Committee will review the appeal decision, and any additional evidence you submit, and make a recommendation. If the Grievance Committee recommends that the relief you sought be granted, you will be promptly informed. If the Grievance Committee recommends that the denial be upheld, you will be notified within 60 days.

Step 4 - Final Internal Appeal

If you are not satisfied with the outcome of the Grievance Hearing, you may submit a written request within 30 days to the Associate Vice President, Human Resource Services, at the University of Kentucky, 101 Scovell Hall, Lexington, KY 40506-0064. The statement should include a summary of the complaint or issue, information regarding previous contact(s) with the plan regarding the matter in question and a description of the relief sought. The UK Director of Employee Benefits has the discretion to establish a committee to perform the Final Appeal process. The Director and/or the committee so established, as applicable, shall review the entire grievance file, including prior decisions rendered on the matter under review, and may request additional information from the participants, prior to rendering the final appeal decision. The final appeal decision will be rendered within 30 days of request.

External Grievance Process

(A) If a Participant has exhausted the Plan's internal appeals process and the Participant is not satisfied or the Plan failed to render a decision within the specific timeframe, a Participant may be eligible for an External Review by an Independent Review Entity under the following conditions:

- (1) The Plan made an adverse determination, as defined in KRS 304.17A-600 (1) (a); Definitions for KRS 304.17A-600 to 304.17A-633:
 - (a) "Adverse determination" means a determination by an insurer or its designee that the health care services furnished or proposed to be furnished to a covered person are:

- i. Not medically necessary, as determined by the insurer, or its designee or experimental or investigational, as determined by the insurer, or its designee; and
 - ii. Benefit coverage is therefore denied, reduced, or terminated.
 - (b) "Adverse determination" does not mean a determination by an insurer or its designee that the health care services furnished or proposed to be furnished to a covered person are specifically limited or excluded in the covered person's health benefit plan;
 - (2) The Participant was enrolled on the date of the service, or, if prospective denial, was enrolled and eligible to receive covered benefits on the date the service was requested; and
 - (3) The entire cost of treatment or service will cost the Participant at least \$100 if not covered by the Plan.
- (B) A Participant, an authorized person or a Provider with the Participant's consent may request an External Review. The request for review must be received within 60 days after the Plan's internal appeal decision letter. The confidentiality of all records used in the review shall be maintained throughout the process. A Participant shall make a request for External Review in writing to the Plan. The written consent authorizing the Independent Review Entity to obtain all necessary medical records from both the Plan and the Provider with information related to the denied coverage shall accompany the request. The Plan shall have consent forms available to Participants upon request to a toll-free telephone number or at an address noted in the Certificate of Coverage.
- (C) The External Review decision shall be rendered by the Independent Review Organization within 21 days after receipt of the request by the Plan. An extension of up to 14 days is permitted if agreed to by both the Participant and the Plan. A participant may request that an appeal be expedited if the Participant is hospitalized or if the normal 21 day timeframe would place the Participant's life at risk. If expedited, the decision shall be made within 24 hours. An extension of up to 24 hours is permitted if the Participant and the Plan agree. If the decision of the Independent Review Organization is in favor of the Participant, the Plan must comply with the decision.
- (D) A Participant requesting External Review shall be assessed a \$25 filing fee that is to be paid to the Independent Review Entity and shall be refunded to the Participant if the final decision is in favor of the Participant. If a Participant is unable to pay the filing fee, the Participant shall request a waiver of the filing fee in writing to the Plan. The cost of External Review shall be paid by the Plan. If the Plan decides that a Participant is not eligible for an External Review and the Participant disagrees, the Participant may file a complaint with the Kentucky Department of Insurance. The Department of

Insurance will render a decision within five days. A Participant with questions about the External Review process may contact the Appeals Department of the Provider or the Plan.

CONTACT INFORMATION

If you have questions about the retail drug program, the mail order program or your prescription order, please call the Express-Scripts toll free Member Services number at 1-877-242-1864 (or 1-800-899-2114 for hearing impaired). These toll-free numbers are listed on the back of your pharmacy benefit member identification card.

You may also obtain information by calling University of Kentucky Employee Benefits Member Services, or by going to the web site address: <http://www.uky.edu/hr/benefits/more-great-benefits/your-prescription-benefit>. You may also contact the UK Prescription Benefit Pharmacists in the UK Employee Benefits Office at 859-218-5979 or 855-218-5979 (toll free)

TERMINATION OF COVERAGE

Coverage under this plan will terminate on the date a participant is no longer enrolled in a covered University of Kentucky Health Plans (UK-HMO, UK-PPO, UK-EPO, UK-RHP, UK HSA Saver, or UK-Indemnity).