

MEDICAL BENEFIT BOOKLET

for the



STANDARD PPO PLAN

Administered By



Si usted necesita ayuda en español para entender este documento, puede solicitarla gratuitamente llamando a Servicios al Cliente al número que se encuentra en su tarjeta de identificación.

If You need assistance in Spanish to understand this document, You may request it for free by calling Customer Service at the number on Your Identification Card.

Effective 1-1-2016

This Benefit Booklet provides You with a description of Your benefits while You are enrolled under the Kentucky Employees' Health Plan (KEHP) (the "Plan") offered by Your Employer. You should read this booklet carefully to familiarize yourself with the Plan's main provisions and keep it handy for reference. A thorough understanding of Your coverage will enable You to use Your benefits wisely. If You have any questions about the benefits as presented in this Benefit Booklet, please contact the Kentucky Employees' Health Plan at 888-581-8834 or call Anthem's Customer Service Department at 844-402-KEHP.

The Plan provides the benefits described in this Benefit Booklet only for eligible Members. The health care services are subject to the Limitations and Exclusions, Copayments, Deductible, and Coinsurance requirements specified in this Benefit Booklet. Any group plan or certificate which You received previously will be replaced by this Benefit Booklet.

Anthem Blue Cross and Blue Shield, or "Anthem" has been designated by KEHP to provide administrative services for the Employer's Group Health Plan, such as claims processing, care management, and other services, and to arrange for a network of health care providers whose services are covered by the Plan.

Important: This is not an insured benefit Plan. The benefits described in this Benefit Booklet are funded by KEHP 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.

Anthem is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, permitting Anthem to use the Blue Cross and Blue Shield Service Marks in portions of the State of Kentucky. Although Anthem is the Claims Administrator and is licensed in Kentucky, You will have access to providers participating in the Blue Cross and Blue Shield Association BlueCard® PPO network across the country. Anthem has entered into a contract with the Employer on its own behalf and not as the agent of the Association.

Verification of Benefits

Verification of Benefits is available for Members or authorized healthcare Providers on behalf of Members. You may call Customer Service with a benefits inquiry or verification of benefits during normal business hours (8:00 a.m. to 8:00 p.m. eastern time). Please remember that a benefits inquiry or verification of benefits is NOT a verification of coverage of a specific medical procedure. Verification of benefits is NOT a guarantee of payment. CALL THE CUSTOMER SERVICE NUMBER ON YOUR IDENTIFICATION CARD or see the section titled Health Care Management for Precertification rules.

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MEMBER RIGHTS AND RESPONSIBILITIES

As a Member You have rights and responsibilities when receiving health care. As Your health care partner, Anthem wants to make sure Your rights are respected while providing Your health benefits. That means giving You access to Anthem's network health care Providers and the information You need to make the best decisions for Your health. As a Member, You should also take an active role in Your care.

You have the right to:

- Speak freely and privately with Your health care Providers about all health care options and treatment needed for Your condition no matter what the cost or whether it is covered under Your Plan.
- Work with your Doctors to make choices about your health care.
- Be treated with respect and dignity.
- Expect Anthem to keep Your personal health information private by following Anthem's privacy policies, and state and Federal laws.
- Get the information You need to help make sure You get the most from Your health Plan, and share Your feedback. This includes information on:
 - Anthem's company and services.
 - Anthem's network of health care Providers.
 - Your rights and responsibilities.
 - The rules of Your health Plan.
 - The way Your health Plan works.
- Make a complaint or file an appeal about:
 - Your health Plan and any care You receive.
 - Any Covered Service or benefit decision that Your health Plan makes.
- Say no to care, for any condition, sickness or disease, without having an effect on any care You may get in the future. This includes asking Your Doctor to tell You how that may affect Your health now and in the future.
- Get the most up-to-date information from a health care Provider about the cause of Your illness, Your treatment and what may result from it. You can ask for help if You do not understand this information.

You have the responsibility to:

- Read all information about Your health benefits and ask for help if You have questions.
- Follow all health Plan rules and policies.
- Choose a Network Primary Care Physician, also called a PCP, if Your health Plan requires it.
- Treat all Doctors, health care Providers and staff with respect.
- Keep all scheduled appointments. Call Your health care Provider's office if You may be late or need to cancel.
- Understand Your health problems as well as You can and work with Your health care Providers to make a treatment plan that You all agree on.
- Inform Your health care Providers if You don't understand any type of care you're getting or what they want You to do as part of Your care plan.
- Follow the health care plan that You have agreed on with Your health care Providers.
- Give Anthem, Your Doctors and other health care Providers the information needed to help You get the best possible care and all the benefits You are eligible for under Your health Plan. This may include information about other health insurance benefits You have along with Your coverage with the Plan.
- Inform Member Services if You have any changes to Your name, address or family members covered under Your Plan.

If You would like more information, have comments, or would like to contact Anthem, please go to anthem.com and select Customer Support > Contact Us. Or call the Member Services number on Your Identification Card.

Anthem wants to provide high quality customer service to our Members. Benefits and coverage for services given under the Plan are governed by the Employer's Plan and not by this Member Rights and Responsibilities statement.

How to Obtain Language Assistance

Anthem is committed to communicating with our members about their health plan, regardless of their language. Anthem employs a Language Line interpretation service for use by all of our Customer Service Call Centers. Simply call the Customer Service phone number on the back of Your ID card and a representative will be able to assist You. Translation of written materials about Your benefits can also be requested by contacting customer service. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with Your needs.

SCHEDULE OF BENEFITS

The Maximum Allowed Amount is the amount Anthem will reimburse for services and supplies which meet its definition of Covered Services, as long as such services and supplies are not excluded under the Member's Plan; are Medically Necessary; and are provided in accordance with the Member's Plan. See the Definitions and Claims Payment sections for more information. Under certain circumstances, if Anthem pays the healthcare provider amounts that are Your responsibility, such as Deductibles, Copayments or Coinsurance, Anthem may collect such amounts directly from You. You agree that Anthem has the right to collect such amounts from You.

Schedule of Benefits	In-Network	Out-of-Network
Calendar Year Deductible		
Individual	\$750	\$1,500
Family – All eligible Members combined	\$1,500	\$3,000
Copayments and charges in excess of the Maximum Allowed Amount do not contribute to the Deductible.		
All Covered Services with Coinsurance are subject to the Deductible, unless otherwise specified in this booklet.		
The Network and Out-of-Network calendar year Deductibles are separate and cannot be combined.		
Coinsurance After the Calendar Year Deductible is Met (Unless Otherwise Specified)		
Plan Pays	70%	50%
Member Pays	30%	50%
All payments are based on the Maximum Allowed Amount and any negotiated arrangements. For Out of Network Providers, You are responsible to pay the difference between the Maximum Allowed Amount and the amount the Provider charges. Depending on the service, this difference can be substantial.		
Out-of-Pocket Maximum Per Calendar Year		
Includes Coinsurance, Copayments and the calendar year Deductible. Does <u>NOT</u> include precertification penalties, charges in excess of the Maximum Allowed Amount, Non-Covered Services, pharmacy claims and services not deemed medically necessary.		
Individual	\$3,500	\$7,000
Family – All eligible Members combined	\$7,000	\$10,000
The Network and Out-of-Network Out-of-Pocket Maximums are separate and cannot be combined.		

Benefits	Network	Out-of-Network
	Member Pays	Member Pays
Note: All Covered Services with Coinsurance are subject to the Deductible, unless otherwise specified in this booklet.		
Allergy Care		
<ul style="list-style-type: none"> • Testing and Treatment • Injections 	30% 30%	50% 50%
Behavioral Health / Substance Abuse Care		
Hospital Inpatient Services	30%	50%
Outpatient Services	30%	50%
Coverage for the treatment of Behavioral Health and Substance Abuse is treated the same as any other health condition in compliance with federal law.		
Clinical Trials Please see Clinical Trials under Benefits section for further information.	Benefits are paid based on the setting in which Covered Services are received	Benefits are paid based on the setting in which Covered Services are received
Dental, Oral Surgery and TMJ Services		
<ul style="list-style-type: none"> • Accidental Injury to natural teeth • Oral Surgery and TMJ Services 	Benefits are paid based on the setting in which Covered Services are received	Benefits are paid based on the setting in which Covered Services are received
Diagnostic Services (non-routine)	30%	50%
Note: Diagnostic services are defined as any claim for services performed to diagnose an illness or Injury.		
Emergency Room, Urgent Care and Ambulance Services		
Emergency room for an Emergency Medical Condition	\$150 then deductible then 30%	\$150 then deductible then 30%
Copayment waived if admitted.		(See note below)
Use of the emergency room for non-Emergency Medical Conditions	Not Covered	Not Covered
Urgent Care clinic visit for an Emergency Medical Condition	30%	30%
		(See note below)

Benefits	Network	Out-of-Network
	Member Pays	Member Pays
Note: All Covered Services with Coinsurance are subject to the Deductible, unless otherwise specified in this booklet.		
Ambulance Services (when Medically Necessary) Land / Air	30%	30% (See note below)
<p>Note: Care received Out-of-Network for an Emergency Medical Condition will be provided at the Network level of benefits if the following conditions apply: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions: (1) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) Serious impairment to bodily functions; or (3) Serious dysfunction of any bodily organ or part. If an Out-of-Network Provider is used, however, You are responsible to pay the difference between the Maximum Allowed Amount and the amount the Out-of-Network Provider charges.</p>		
Eye Care (non-routine) <ul style="list-style-type: none"> Office visit – medical eye care exams (treatment of disease or injury to the eye) 	30%	50%
Hearing Care (non-routine) <ul style="list-style-type: none"> Office visit – Audiometric exam / hearing evaluation test (treatment of disease or injury to the ear) 	30%	50%
<ul style="list-style-type: none"> Hearing Aids and Hearing Aid-Related Services 	30%	50%
Children – 17 and under	Limited to one hearing aid per each hearing impaired ear, every 36 months.	
Adults – 18 and over	Limited to one hearing aid per hearing impaired ear, up to a maximum of \$1,400 per ear, every 36 months.	
Home Health Care Services <ul style="list-style-type: none"> Maximum Home Care visits (combined with Private Duty Nursing visits) 	30%	50%
	60 visits per calendar year combined Network and Out-of-Network	
Hospice Care Services	Covered in Full	Covered in Full
Hospital Inpatient Services	30%	50%
Hospital Outpatient Services	30%	50%
Maternity Care & Other Reproductive Services		

Benefits	Network	Out-of-Network
	Member Pays	Member Pays
Note: All Covered Services with Coinsurance are subject to the Deductible, unless otherwise specified in this booklet.		
<ul style="list-style-type: none"> • Maternity Care • Infertility Services (diagnosis only) • Sterilization Services <p style="margin-left: 20px;">Sterilizations for women will be covered under the "Preventive Care" benefit. Please see that section in Benefits for further details.</p>	<p>30%</p> <p>30%</p> <p>Benefits are paid based on the setting in which Covered Services are received</p>	<p>50%</p> <p>50%</p> <p>Benefits are paid based on the setting in which Covered Services are received</p>

Benefits	Network	Out-of-Network
	Member Pays	Member Pays
Note: All Covered Services with Coinsurance are subject to the Deductible, unless otherwise specified in this booklet.		
Medical Supplies and Equipment		
• Medical Supplies	30%	30%
• Durable Medical Equipment	30%	30%
• Orthotics Foot and Shoe	30%	50%
• Prosthetic Appliances (external)	30%	50%
Nutritional Counseling	30%	50%
Office Surgery	30%	50%
Online Visits – LiveHealth Online only	0%	Not Covered
Physician Services (Home and Office Visits)	30%	50%
Preventive Services (regardless of Provider or setting where Preventive care is provided) Well Child/Well Adult	Covered in Full	50%
Note: Preventive Services are defined as any claim submitted with a “well” diagnosis.		
Skilled Nursing Facility	30%	50%
• Maximum days	30 days per calendar year combined In-Network and Out-of-Network	
Therapy Services (Outpatient)		
• Physical Therapy	30%	50%
• Occupational Therapy	30%	50%
• Speech Therapy	30%	50%
• Cardiac Rehabilitation	30%	50%
• Radiation Therapy	30%	50%
• Chemotherapy	30%	50%
• Respiratory Therapy	30%	50%
• Chiropractic Care	30%	50%
• Vision Therapy	Not Covered	Not Covered
Note: Inpatient therapy services will be paid under the Inpatient Hospital benefit.		
Note: All therapy services are limited to 1 visit per day per therapy.		

Benefits	Network	Out-of-Network
	Member Pays	Member Pays
Note: All Covered Services with Coinsurance are subject to the Deductible, unless otherwise specified in this booklet.		
Benefits for physical therapy are limited to 30 visits per calendar year, combined Network and Out-of-Network.		
Benefits for occupational therapy are limited to 30 visits per calendar year, combined In-Network and Out-of-Network.		
Benefits for speech therapy are limited to 30 visits per calendar year, combined In-Network and Out-of-Network.		
Benefits for chiropractic care are limited to 26 visits per calendar year, combined In-Network and Out-of-Network.		
Transplants		
Any Medically Necessary human organ and stem cell/bone marrow transplant and transfusion as determined by Anthem including necessary acquisition procedures, collection and storage, including Medically Necessary preparatory myeloablative therapy.	Center of Excellence/ In-Network Transplant Provider	Out-of-Network Transplant Provider
Transplant Benefit Period	Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period (The number of days will vary depending on the type of transplant received and the Center of Excellence Network Transplant Provider agreement. Contact the Customer Service number on Your Identification Card and ask for the Transplant Case Manager for specific Network Transplant Provider information.)	Starts one day prior to a Covered Transplant Procedure and continues to the date of discharge.
<ul style="list-style-type: none"> <li data-bbox="131 1822 878 1875">Covered Transplant Procedure during the Transplant 	30%	50%

Benefits	Network	Out-of-Network
	Member Pays	Member Pays
Note: All Covered Services with Coinsurance are subject to the Deductible, unless otherwise specified in this booklet.		
Benefit Period		
<ul style="list-style-type: none"> • Bone Marrow & Stem Cell Transplant (Inpatient & Outpatient) 	30%	50%
<ul style="list-style-type: none"> • Live Donor Health Services (including complications from the donor procedure for up to six weeks from the date of procurement) 	30%	50%
<ul style="list-style-type: none"> • Eligible Travel and Lodging 	30%	50%

TOTAL HEALTH AND WELLNESS SOLUTION

Future Moms

The Future Moms program offers a guided course of care and treatment, leading to overall healthier outcomes for mothers and their newborns. Future Moms helps routine to high-risk expectant mothers focus on early prenatal interventions, risk assessments and education. The program includes special management emphasis for expectant mothers at highest risk for premature birth or other serious maternal issues. The program consists of nurse coaches, supported by pharmacists, registered dietitians, social workers and medical directors. You'll get:

- 24/7 phone access to a nurse coach who can talk with you about your pregnancy and answer your questions.
- *Your Pregnancy Week by Week*, a book to show you what changes you can expect for you and your baby over the next nine months.
- Useful tools to help you, your doctor and your Future Moms nurse coach track your pregnancy and spot possible risks.

Quick Care Options

Quick Care Options helps to raise Your awareness about appropriate alternatives to hospital emergency rooms (ERs). When You need care right away, retail health clinics and urgent care centers can offer appropriate care for less cost—and leave the ER available for actual emergencies. Quick Care Options educates You on the availability of ER alternatives for non-urgent diagnoses and provides provider finder website to support searches for ER alternatives.

MyHealth Advantage

MyHealth Advantage is a free service that helps keep You and Your bank account healthier. Here's how it works: Anthem reviews Your incoming health claims to see if we can save You any money. Anthem can check to see what medications You're taking and alert Your doctor if we spot a potential drug interaction. Anthem also keeps track of Your routine tests and checkups, reminding You to make these appointments by mailing You MyHealth Note. MyHealth Notes summarize Your recent claims. From time to time, Anthem offers tips to save You money on prescription drugs and other health care supplies.

Personal Health Consultant Programs

Personal Health Consultant programs help maximize Your health status, improve health outcomes and control health care expenses associated with the following prevalent conditions:

- Asthma (pediatric and adult).
- Diabetes (pediatric and adult).
- Heart failure (HF).
- Coronary artery disease (CAD).
- Chronic obstructive pulmonary disease (COPD).
- Low Back Pain – focuses on disorders of the lumbar region.
- Hypertension – focuses on knowing and understanding your numbers and how uncontrolled high blood pressure can lead to other issues
- Metabolic Syndrome – focuses on obesity as more than just a weight problem and provides better understanding of impact to your overall health

You'll get:

- 24/7 phone access to a personal health consultant who can answer your questions and give you up-to-date information about your condition.
- A health review and follow-up calls if you need them.
- Tips on prevention and lifestyle choices to help you improve your quality of life.

AIM Imaging Cost & Quality Program

KEHP has selected this innovative Imaging Cost & Quality Program for Anthem Blue Cross Blue Shield members through AIM Specialty Health. This Program provides You with access to important information about imaging services You might need. The Program is a service provided by Anthem and is not a benefit under your health benefit plan.

If You need an MRI or a CT scan, it's important to know that costs can vary quite a bit depending on where You go to receive the service. Sometimes the differences are significant – anywhere from \$300 to \$3000 – but a higher price doesn't guarantee higher quality. If your benefit plan requires You to pay a portion of this cost (like a deductible or coinsurance) where You go can make a very big difference to your wallet.

That's where the AIM Imaging Cost & Quality Program comes in – AIM does the research for You and makes it available to help You find the right location for your MRI or CT scan. Here's how the Program works:

- Your doctor refers You to a radiology provider for an MRI or CT scan
- AIM works with your doctor to help make sure that You are receiving the right test – using evidence-based guidelines
- AIM also reviews the referral to see if there are other providers in your area that are high quality but have a lower price than the one You were referred to
- If AIM finds another provider that meets the quality and price criteria,, AIM will give You a call to let You know
- You have the choice – You can see the radiology provider your doctor suggested OR You can choose to see a provider that AIM tells You about. AIM will even help You schedule an appointment with the new provider

The AIM Imaging Cost & Quality Program gives You the opportunity to reduce your health care expenses (and those of your employer) by selecting high quality, lower cost providers or locations. No matter which provider You choose, there is no effect on your health care benefits. We are bringing this Program to You to give You information that helps You to make informed choices about where to go when You need care. For some services, You may be eligible for incentives through Vitals.

Sleep Study Program

Your Plan includes benefits for a Sleep Management Program, which is a program that helps Your doctor make better informed decisions about Your treatment. It is administered by AIM Specialty Health which is a wholly-owned division of Anthem Blue Cross Blue Shield. The Sleep Management Program includes outpatient and home sleep testing and therapy. If You require sleep testing, depending on Your medical condition, You may be asked to complete the sleep study in Your home. Home sleep studies provide the added benefit of reflecting Your normal sleep pattern while sleeping in the comfort of Your own bed versus going to an outpatient facility for the test.

As part of this program, You are required to get precertification for:

- Home sleep tests (HST)
- In-lab sleep studies (polysomnography or PSG, a recording of behavior during sleep)
- Titration studies (to determine the exact pressure needed for treatment)
- Treatment orders for equipment, including positive airway pressure devices (APAP, CPAP, BPAP, ASV), oral devices and related supplies.

If You need ongoing treatment, AIM will review Your care quarterly to assure that medical criteria are met for coverage. Your equipment supplier or Your doctor will be required to provide periodic updates to ensure clinical appropriateness. Ongoing claim approval will depend partly on how You comply with the treatment Your doctor has ordered. Please talk to Your doctor about getting approval for any sleep testing and therapy equipment and supplies. If You have questions about Your care, please talk with Your doctor. For questions about Your Plan or benefits, please call Customer Service.

ELIGIBILITY

Employee and Dependent Eligibility

You should contact Your Employer to determine if You and Your Dependents are eligible for coverage under KEHP. The covered Employee may cover Dependents only if the Employee is also covered.

You may add new Dependents if there is a valid qualifying event such as marriage, birth, and adoption by contacting Your Employer. There are time limits to adding a new Dependent outside of open enrollment. Late enrollment will result in denial of Dependent coverage until the next annual open enrollment period.

In any event, no person may be simultaneously covered as both an Employee and a Dependent under KEHP. If both parents are eligible for coverage, the Dependent may only enroll under one Plan.

KEHP may require supporting documentation to verify the eligibility of any Dependent enrolled or requesting to be enrolled in the Plan.

Adding a Dependent to the Plan who does not meet the KEHP eligibility rules may be considered insurance fraud.

Retiree Eligibility and Coverage

A "retiree" is a recipient of a retirement allowance from the Kentucky Retirement Systems, Kentucky Teachers' Retirement System, the Legislators' Retirement Plan, the Judicial Retirement Plan, or the Kentucky Community and Technical College System's optional retirement plan. If You are a retiree who is under age 65 or is age 65 or older and non-Medicare eligible, You may enroll or continue coverage under the Plan for You and any of Your eligible Dependents. Please contact Your retirement system for more details regarding eligibility and enrollment.

Open Enrollment

Once annually You will have a choice of enrolling Yourself and Your eligible Dependents in this Plan. This is referred to as open enrollment. You may also change your plan options during open enrollment.

You will be notified in advance when the open enrollment period begins and when it will end. If You initially declined coverage for Yourself or Your Dependents at the time You were initially eligible for coverage, You will be able to enroll Yourself and/or Your eligible Dependents during the open enrollment period.

When Coverage Begins

If the Employee applies for coverage when first eligible, coverage will be effective on the date the Employer's length-of-service requirement has been met. The Effective Date of coverage is subject to any length-of-service provision the Employer requires and will not exceed 90 days. KEHP coverage begins for the Employee on the first day of the second month following the month of hire.

Extension of Benefits. If an Employee or Dependent was insured with an insurance carrier and enrolls in KEHP coverage during open enrollment, KEHP shall provide coverage beginning January 1 of the plan year following open enrollment, except for the following:

1. If a Member is hospitalized when coverage would normally terminate with a prior Insurance Carrier, the prior Insurance Carrier that covered the Member's hospitalization during the previous plan year would continue coverage until the Member is released from the hospital or transferred to another facility. At the time the Member is released from the hospital or transferred to a new

facility, the KEHP will assume responsibility for that Member. It is the Member's responsibility to ensure that a transfer or re-hospitalization is to a participating facility in compliance with all Plan delivery rules.

2. If a Member has family coverage and a Covered Dependent is hospitalized when coverage would normally terminate with a prior Insurance Carrier, the hospitalized Covered Dependent would continue his/her coverage with the prior Insurance Carrier until discharged from the hospital or transferred to another facility. All other Covered Dependents not hospitalized at the date the new coverage begins with KEHP will be covered under KEHP on the date the new coverage starts (not on the date the hospitalized Dependent is released or transferred).

Employee Not Actively at Work. Generally, if an Employee is not actively at work on the date his or her coverage is to be effective, the Effective Date will be postponed until the date the Employee returns to active status. If an Employee is not actively at work due to health status, this provision will not apply. An Employee is also a person still employed by the Employer but not currently active due to health status.

These Extension of Benefits and Actively and Work provisions take precedence over all Extension of Benefits clauses and Actively at Work provisions contained in any of the insurance carrier's standard commercial contracts in compliance with KRS 304.18-126 and KRS 304.18-127.

Changing Coverage or Removing a Dependent

When any of the following events occur, notify the Employer and ask for appropriate forms to complete:

- Divorce;
- Death of an enrolled family member (a different coverage level may be necessary);
- Dependent child reaches age 26; and
- Enrolled Dependent child becomes totally or permanently disabled.

Types of Coverage

The types of coverage available to the Employee are indicated at the time of enrollment through the Employer.

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.

Family Cross-Reference Payment Option

Contact your Employer to obtain information regarding the cross-reference payment option which is available through KEHP if:

- Two Employees are legally married Spouses with at least one eligible Dependent, excluding the Spouse;
- The Employees are Eligible Employees or retirees* of a group participating in KEHP;
- The Employees elect the same coverage option; and
- The Employees both complete an enrollment application complete with signatures from both Employees and their agency's insurance coordinators.

The failure to meet any one of the above requirements means that You are not eligible for the cross-reference payment option.

* *Members* of the Judicial and Legislators Retirement Plans are not eligible to elect the cross-reference payment option.

OBRA 1993 and Qualified Medical Child Support Orders

The Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) provides specific rules for the coverage of adopted children and children subject to a Qualified Medical Child Support Order (QMCSO).

An eligible Dependent child includes:

- An adopted child, regardless of whether or not the adoption has become final.
- An “adopted child” is any person under the age of 18 as of the date of adoption or placement for adoption. “Placement for adoption” means the assumption and retention by the Employee of the legal obligation for the total or partial support of a child to be adopted. Placement ends whenever the legal support obligation ends.
- A child for whom an Employee has received an MCSO (a “Medical Child Support Order”) which has been determined by the Employer or Plan Administrator to be a Qualified Medical Child Support Order (“QMCSO”).
- Upon receipt of a QMCSO, the Employer or Plan Administrator will inform the Employee and each affected child of its receipt of the order and will explain the procedures for determining if the order is a QMCSO. The Employer will subsequently notify the Employee and the child(ren) of the determination.

A QMCSO cannot require the Employer to provide any type or form of benefit that it is not already offering.

Special Provisions Regarding Leave

If Your Employer continues to pay required contributions and does not terminate the Plan, Your coverage will remain in force for a period of time as determined by Your Employer for a layoff, during an approved medical leave of absence, during a period of total disability, during an approved non-medical leave of absence, during an approved military leave of absence or during part-time status.

If Your coverage under this Plan was terminated after a period of layoff, total disability, approved medical leave of absence, approved non-medical leave of absence or during part-time status and You are now returning to work, Your coverage is effective as determined by Your Employer. The eligibility period requirement with respect to the reinstatement of Your coverage will be determined by Your Employer.

If Your coverage under this Plan was terminated after an approved military leave of absence (other than USERRA) or during part-time status and You are now returning to work, Your coverage is effective as determined by Your Employer. The eligibility period requirement with respect to the reinstatement of Your coverage will be determined by Your Employer.

If Your coverage under the Plan was terminated due to a period of service in the uniformed services covered under the Uniformed Services Employment and Reemployment Rights Act of 1994, Your coverage is effective immediately on the day You return to work. Eligibility waiting period limitations will be imposed only to the extent they were applicable prior to the period of service in the uniformed services.

Family and Medical Leave

If a covered Employee ceases active employment due to an Employer-approved medical leave of absence, in accordance with the Family and Medical Leave Act of 1993 (FMLA), coverage will be continued for up to 12 weeks under the same terms and conditions which would have applied had the Employee continued in active employment. The Employee must pay his or her contribution share toward the cost of coverage, if any contribution is required.

Terminating Employment

KEHP is a current pay health insurance plan. If You leave employment between the 1st and the 15th of the month, Your health insurance coverage will terminate on the 15th of the same month. If You leave employment between the 16th and the end of the month, Your health insurance coverage will terminate on the last day of the same month.

Survivorship Coverage

If the Employee dies while Dependent coverage is in force, the surviving Spouse and Dependent children may continue to be covered through the COBRA provision.

Special Enrollment

1. If You decline enrollment for Yourself or Your eligible Dependent(s) (including your Spouse) because of other health insurance or group health plan coverage, You may be able to enroll Yourself and Your Dependents in this plan if You or Your Dependents lose eligibility for that other coverage (or if the employer stops contributing toward Your or Your Dependents' other coverage). However, You must request enrollment within 35 days after Your or Your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage).
2. 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 new Dependent(s). However, You must request enrollment within 35 days after the marriage and within 60 days after birth, adoption, or placement for adoption.
3. If You or Your children are eligible for Medicaid or the Children's Health Insurance Program (CHIP) and You're eligible for health coverage from Your Employer, Kentucky may have a premium assistance program that can help pay for coverage using funds from the state's Medicaid or CHIP programs. If You or Your Dependent(s) are eligible for premium assistance under Medicaid or CHIP, as well as eligible for health insurance coverage through KEHP, Your Employer must allow You to enroll in KEHP if you aren't already enrolled. This is called a "special enrollment" opportunity, and You must request coverage within 60 days of being determined eligible for premium assistance. In addition, You may enroll in KEHP if You or Your Dependent's Medicaid or CHIP coverage is terminated as a result of loss of eligibility. An Employee must request this special enrollment within 60 days of the loss of coverage. More information and the required CHIP Notice may be found at kehp.ky.gov.

When Coverage Terminates

Coverage terminates on the earliest of the following:

1. The date this Plan terminates;
2. The end of the period for which any required contribution was due and not paid;
3. As determined by Your Employer when You enter full-time military, naval or air service, except coverage may continue during an approved military leave of absence as indicated in the Special Provisions;
4. The date determined by Your Employer, when You fail to be in an eligible class of persons according to the eligibility requirements of the Employer;
5. For all Employees, as determined by Your Employer, following termination of employment with the Employer;
6. The date determined by Your Employer after You request termination of coverage to be effective for Yourself or Your Covered Dependents based on valid qualifying event guidelines;

7. For any benefit, the date the benefit is removed from this Plan;
8. For Your Dependents, the date Your coverage terminates;
9. For a Dependent, the date determined by Your Employer the Dependent enters full-time military, naval or air service;
10. For a Dependent, the date determined by Your Employer such Covered Dependent no longer meets the definition of Dependent;
11. coverage of an enrolled child ceases at the end of the month when the child attains the age limit shown in the Eligibility section;
12. ;Coverage of a disabled child over age 26 ceases if the child is found to be no longer totally or permanently disabled.

Should You or any family Members be receiving covered care in the Hospital at the time Your membership terminates for reasons other than Your Employer's cancellation of this Plan, or failure to pay the required Premiums, benefits for Hospital Inpatient care will be provided until the date You are discharged from the Hospital.

KEHP is a current pay health insurance plan. If you leave employment between the 1st and the 15th of the month, your health insurance coverage will terminate on the 15th of the same month. If you leave employment between the 16th and the end of the month, your health insurance coverage will terminate on the last day of the same month.

If You or any of Your Covered Dependents no longer meet the eligibility requirements of Your Employer or the Plan, You and Your Employer are responsible for notifying Your insurance coordinator of the change in status. Coverage will not continue beyond the end of the semi-monthly period in which eligibility ends even if notice has not been given to Anthem, the Employer, or the Plan Sponsor (Commonwealth of Kentucky).

Entitlement to Medicare

If an Employee, Spouse, or Dependent who is enrolled in the Plan becomes entitled to coverage (e.g., becomes enrolled) under Part A or Part B of Medicare, other than coverage consisting solely of benefits under section 1928 of Social Security Act, the Employee may make a prospective election change to cancel coverage of that Employee, Spouse, or Dependent under the Plan. In addition, if an Employee, Spouse, or Dependent who has been entitled to coverage under Medicare loses eligibility for such coverage, the Employee may make a prospective election to commence coverage of that Employee, Spouse, or Dependent under the Plan.

Coverage may be elected under this Plan provided enrollment is within 35 days from the loss of entitlement to Medicare.

HOW YOUR PLAN WORKS

Note: Capitalized terms such as Covered Services, Medical Necessity, and Out-of-Pocket Maximum are defined in the “Definitions” Section.

Introduction

Your health Plan is a Preferred Provider Organization (PPO) which is a comprehensive Plan. The Plan is divided into two sets of benefits: In-Network and Out-of-Network. If You choose an In-Network Provider, You will receive In-Network benefits. Utilizing this method means You will not have to pay as much money; Your Out-of-Pocket expenses will be higher when You use Out-of-Network Providers.

All Covered Services must be Medically Necessary, and coverage or certification of services that are not Medically Necessary may be denied.

Network Services

When You use a Network Provider or get care as part of an Authorized Service, Covered Services will be covered at the Network level. Regardless of Medical Necessity, benefits will be denied for care that is not a Covered Service. The Plan has the final authority to decide the Medical Necessity of the service.

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 a 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.

For services from Network Providers:

1. You will not need to file claims. 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 Network Provider(s) for any Non-Covered Services You get or when You have not followed the terms of this Benefit Booklet.
2. Precertification will be done by the Network Provider. (See the **Health Care Management – Precertification** 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.

Out-of-Network Services

When You do not use a Network Provider or get care as part of an Authorized Service, Covered Services are covered at the Out-of-Network level, unless otherwise indicated in this Benefit Booklet.

For services from an Out-of-Network Provider:

- the Out-of-Network Provider can charge You the difference between their bill and the Plan's Maximum Allowed Amount plus any Deductible and/or Coinsurance/Copayments;
- You may have higher cost sharing amounts (i.e., Deductibles, Coinsurance, and/or Copayments);
- You will have to pay for services that are not Medically Necessary;
- You will have to pay for Non-Covered Services;
- You may have to file claims; and
- You must make sure any necessary Precertification is done. (Please see **Health Care Management – Precertification** for more details.)

How to Find a Provider in the Network

There are three 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 Network Providers at www.anthem.com, which lists the Doctors, Providers, and facilities that participate in this Plan's Network.
- Call Customer Service to ask for a list of doctors and Providers that participate in this Plan's Network, based on specialty and geographic area.
- 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 Customer Service 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.

The BlueCard Program

Like all Blue Cross & Blue Shield plans throughout the country, Anthem participates in a program called "BlueCard." This program lets You get Covered Services at the Network cost-share when You are traveling out of state and need health care, as long as You use a BlueCard Provider. All You have to do is show your Identification Card to a participating Blue Cross & Blue Shield Provider, and they will send Your claims to Anthem.

If You are out of state and an Emergency or urgent situation arises, You should get care right away.

In a non-Emergency situation, You can find the nearest contracted Provider by visiting the BlueCard Doctor and Hospital Finder website (www.BCBS.com) or call the number on the back of your Identification Card.

You can also access Doctors and Hospitals outside of the U.S. The BlueCard program is recognized in more than 200 countries throughout the world.

Please refer to **Inter-Plan Programs** in the **Claims Payment** section for more information on BlueCard.

Care Outside the United States – BlueCard® Worldwide

Prior to travel outside the United States, check with Your Group or call Customer Service at the number on your Identification Card to find out if Your Plan has BlueCard Worldwide benefits. Your coverage outside the United States may be different and we recommend:

- Before You leave home, call the Customer Service number on your Identification Card for coverage details.
- Always carry your current Identification Card.
- In an emergency, go directly to the nearest Hospital.
- The BlueCard Worldwide Service Center is available 24 hours a day, seven days a week toll-free at (800) 810-BLUE (2583) or by calling collect at (804) 673-1177. An assistance coordinator, along with a medical professional, will arrange a Physician appointment or hospitalization, if needed.

Call the Service Center in these non-emergent situations:

- You need to find a Physician or Hospital or need medical assistance services. An assistance coordinator, along with a medical professional, will arrange a Physician appointment or hospitalization, if needed.
- You need to be hospitalized or need Inpatient care. After calling the Service Center, You must also call Anthem to obtain approval for benefits at the phone number on your Identification Card. Note: this number is different than the phone numbers listed above for BlueCard Worldwide.

Payment Information

- **Participating BlueCard Worldwide Hospitals.** In most cases, when You make arrangements for hospitalization through BlueCard Worldwide, You should not need to pay upfront for Inpatient care at participating BlueCard Worldwide hospitals except for the Out-of-Pocket costs (non-Covered Services, Deductible, Copayments and Coinsurance) You normally pay. The Hospital should submit Your claim on Your behalf.
- **Doctors and/or non-participating Hospitals.** You will need to pay upfront for outpatient services, care received from a Doctor, and Inpatient care not arranged through the BlueCard Worldwide Service Center. Then You can complete a BlueCard Worldwide claim form and send it with the original bill(s) to the BlueCard Worldwide Service Center (the address is on the form).

Claim Filing

- The Hospital will file your claim if the BlueCard Worldwide Service Center arranged Your hospitalization. You will need to pay the Hospital for the Out-of-Pocket costs You normally pay.
- You must file the claim for outpatient and Physician care, or Inpatient care not arranged through the BlueCard Worldwide Service Center. You will need to pay the Provider and subsequently send an international claim form with the original bills to Anthem.

Claim Forms

International claim forms are available from Anthem, the BlueCard Worldwide Service Center, or online at www.bcbs.com/bluecardworldwide. The address for submitting claims is on the form.

Copayment

Certain Network services may be subject to a Copayment amount which is a flat-dollar amount You will be charged at the time services are rendered.

Copayments are the responsibility of the Member. Any Copayment amounts required are shown in the **Schedule of Benefits**. Unless otherwise indicated, services which are not specifically identified in this Benefit Booklet as being subject to a Copayment are subject to the **calendar year Deductible** and payable at the **percentage payable** in the **Schedule of Benefits**.

Calendar Year Deductible

Before the Plan begins to pay benefits (except certain benefits which are subject to Copayment instead of Deductible), You must meet any Deductible required. . Deductible requirements are stated in the **Schedule of Benefits**.

HEALTH CARE MANAGEMENT - PRECERTIFICATION

Your Plan includes the processes of Precertification, Predetermination and Post Service Clinical Claims Review to determine when services should be covered by Your Plan. Their purpose is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place of service that they are performed. Your Plan requires that Covered Services be Medically Necessary for benefits to be provided. When setting or place of service is part of the review, services that can be safely provided to You in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting.

Prior Authorization: Network Providers are required to obtain prior authorization in order for You to receive benefits for certain services. Prior authorization criteria will be based on multiple sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. Anthem may determine that a service that was initially prescribed or requested is not Medically Necessary if You have not previously tried alternative treatments which are more cost effective.

If You have any questions regarding the information contained in this section, You may call the Customer Service telephone number on Your Identification Card or visit www.anthem.com.

Types of Requests:

Precertification – A required review of a service, treatment or admission for a benefit coverage determination which must be obtained prior to the service, treatment or admission start date. For emergency admissions, You, Your authorized representative or Physician must notify Anthem within 2 business days after the admission or as soon as possible within a reasonable period of time. For childbirth admissions, Precertification is not required unless there is a complication and/or the mother and baby are not discharged at the same time.

Predetermination – An optional, voluntary Prospective or Concurrent/Continued Stay Review request for a benefit coverage determination for a service or treatment. Anthem will review Your Plan to determine if there is an exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to determine whether the service meets the definition of Medical Necessity under this Plan or is Experimental/Investigative as that term is defined in this Plan.

Post Service Clinical Claims Review– A Retrospective review for a benefit coverage determination to determine the Medical Necessity or Experimental/Investigative nature of a service, treatment or admission that did not require Precertification and did not have a Predetermination review performed. Medical Reviews occur for a service, treatment or admission in which Anthem has a related clinical coverage guideline and are typically initiated by Anthem

Failure to Obtain Precertification Penalty:

IMPORTANT NOTE: IF YOU OR YOUR NON NETWORK PROVIDER DO NOT OBTAIN THE REQUIRED PRECERTIFICATION, A PENALTY WILL APPLY AND YOUR OUT OF POCKET COSTS WILL INCREASE. THIS DOES NOT APPLY TO MEDICALLY NECESSARY SERVICES FROM A NETWORK OR BLUECARD PROVIDER.

The following list is not all inclusive and is subject to change; please call the Customer Service telephone number on Your Identification Card to confirm the most current list and requirements for Your Plan.

Inpatient Admission:

- All acute Inpatient, Skilled Nursing Facility, Long Term Acute Rehabilitation, and Obstetrical delivery stays beyond the 48/96 hour Federal mandate length of stay minimum (including newborn stays beyond the mother's stay)
- Emergency Admissions (requires Plan notification no later than 2 business days after admission)

Outpatient Services:

- Ablative Techniques as a Treatment for Barrett's Esophagus
- Air Ambulance (excludes 911 initiated emergency transport)
- Artificial Intervertebral Discs
- Balloon Sinuplasty
- Bone-Anchored Hearing Aids
- Breast Procedures; including Reconstructive Surgery, Implants, Reduction , Mastectomy for Gynecomastia and other Breast Procedures
- Canaloplasty
- Cardiac Resynchronization Therapy (CRT) with or without an Implantable Cardioverter Defibrillator (CRT/ICD) for the Treatment of Heart Failure
- Carotid, Vertebral and Intracranial Artery Angioplasty with or without Stent Placement
- Cochlear Implants and Auditory Brainstem Implants
- Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedures
- Cryoablation for Plantar Fasciitis and Plantar Fibroma
- Cryopreservation of Oocytes or Ovarian Tissue
- Cryosurgical Ablation of Solid Tumors Outside the Liver
- Deep Brain Stimulation
- Diagnostic Testing
 - ▶ Diagnosis of Sleep Disorders
- DME/Prosthetics
 - ▶ Bone Growth Stimulator: Electrical or Ultrasound
 - ▶ Communication Assisting / Speech Generating Devices
 - ▶ External (Portable) Continuous Insulin Infusion Pump
 - ▶ Functional Electrical Stimulation (FES); Threshold Electrical Stimulation (TES)
 - ▶ Microprocessor Controlled Lower Limb Prosthesis
 - ▶ Oscillatory Devices for Airway Clearance including High Frequency Chest Compression and Intrapulmonary Percussive Ventilation (IPV)
 - ▶ Pneumatic Pressure Device with Calibrated Pressure
 - ▶ Power Wheeled Mobility Devices
 - ▶ Prosthetics: Electronic or externally powered and select other prosthetics
 - ▶ Standing Frame
- Electrothermal Shrinkage of Joint Capsules, Ligaments, and Tendons

- Extracorporeal Shock Wave Therapy for Orthopedic Conditions
- Functional Endoscopic Sinus Surgery
- Gastric Electrical Stimulation
- Gene Expression Profiling for Managing Breast Cancer Treatment
- Genetic Testing for Cancer Susceptibility
- Implantable or Wearable Cardioverter-Defibrillator
- Implantable Infusion Pumps
- Implantable Middle Ear Hearing Aids
- Implanted Devices for Spinal Stenosis
- Implanted Spinal Cord Stimulators
- Intraocular Anterior Segment Aqueous Drainage Devices (without extraocular reservoir)
- Locally Ablative Techniques for Treating Primary and Metastatic Liver Malignancies
- Lumbar spinal surgeries
- Lung Volume Reduction Surgery
- Lysis of Epidural Adhesions
- Manipulation Under Anesthesia of the Spine and Joints other than the Knee
- Maze Procedure
- MRI Guided High Intensity Focused Ultrasound Ablation of Uterine Fibroids
- Oral, Pharyngeal & Maxillofacial Surgical Treatment for Obstructive Sleep Apnea
- Occipital nerve stimulation
- Orthognathic Surgery
- Ovarian and Internal Iliac Vein Embolization as a Treatment of Pelvic Congestion Syndrome
- Partial Left Ventriculectomy
- Penile Prosthesis Implantation
- Percutaneous Neurolysis for Chronic Back Pain
- Percutaneous Spinal Procedures
- Photocoagulation of Macular Drusen
- Physician Attendance and Supervision of Hyperbaric Oxygen Therapy
- Plastic/Reconstructive surgeries:
 - ▶ Abdominoplasty ,Panniculectomy, Diastasis Recti Repair
 - ▶ Blepharoplasty
 - ▶ Brachioplasty
 - ▶ Buttock/Thigh Lift
 - ▶ Chin Implant, Mentoplasty, Osteoplasty Mandible
 - ▶ Insertion/Injection of Prosthetic Material Collagen Implants
 - ▶ Liposuction/Lipectomy
 - ▶ Procedures Performed on Male or Female Genitalia
 - ▶ Procedures Performed on the Face, Jaw or Neck (including facial dermabrasion, scar revision)
 - ▶ Procedures Performed on the Trunk and Groin
 - ▶ Repair of Pectus Excavatum / Carinatum

- ▶ Rhinoplasty
- ▶ Skin-Related Procedures
- Presbyopia and Astigmatism-Correcting Intraocular Lenses
- Private Duty Nursing
- Radiation therapy
 - ▶ Intensity Modulated Radiation Therapy (IMRT)
 - ▶ Proton Beam Therapy
- Radiofrequency Ablation to Treat Tumors Outside the Liver
- Real-Time Remote Heart Monitors
- Sacral Nerve Stimulation as a Treatment of Neurogenic Bladder Secondary to Spinal Cord Injury
- Sacroiliac Joint Fusion
- Septoplasty
- Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiotherapy (SBRT)
- Subtalar Arthroereisis
- Suprachoroidal Injection of a Pharmacologic Agent
- Surgical and Minimally Invasive Treatments for Benign Prostatic Hyperplasia (BPH) and Other GU Conditions
- Surgical Treatment of Migraine Headaches
- Thoracoscopy for Treatment of Hyperhidrosis
- Tonsillectomy in Children
- Total Ankle Replacement
- Transcatheter Closure of Cardiac Defects
- Transcatheter Uterine Artery Embolization
- Transmyocardial Preventicular Device
- Transtympanic Micropressure for the Treatment of Ménière's Disease
- Treatment of Obstructive Sleep Apnea, UPPP
- Treatment of Osteochondral Defects of the Knee and Ankle
- Treatment of Temporomandibular Disorders
- Vagus Nerve Stimulation
- Varicose Vein Treatment

Human Organ and Bone Marrow/Stem Cell Transplants

- Inpatient admissions for **ALL** solid organ and bone marrow/stem cell transplants (Including Kidney only transplants)
- All Outpatient services for the following:
 - Stem Cell/Bone Marrow transplant (with or without myeloablative therapy)
 - Donor Leukocyte Infusion

Out of Network Referrals:

Out of Network Services for consideration of payment at Network benefit level (may be authorized, based on Network availability and/or Medical Necessity.)

Mental Health/Substance Abuse (MHSA):

Pre-certification Required

- Acute Inpatient Admissions
- Electric Convulsive Therapy (ECT)
- Transcranial Magnetic Stimulation (TMS)
- Intensive Outpatient Therapy (IOP)
- Partial Hospitalization (PHP)
- Residential Care
- ABA- Applied Behavioral Analysis

The following services do not require precertification, but are recommended for pre-determination of Medical Necessity due to the existence of post service claim review criteria and/or the potential cost of services to the Member if denied for lack of Medical Necessity: Procedures, equipment, and/or specialty infusion drugs which have Medically Necessary criteria determined by Anthem’s Medical Policy or Clinical Guidelines.

Who is responsible for Precertification?	
<p>Services provided by a Network Provider, including BlueCard Providers in the service areas of Anthem Blue Cross and Blue Shield (CO, CT, IN, KY, ME, MO, NH, NV, OH, VA, WI); Anthem Blue Cross (CA); Empire Blue Cross Blue Shield; Blue Cross Blue Shield of Georgia; and any future affiliated Blue Cross and/or Blue Shield plans resulting from a merger or acquisition by Anthem’s parent company.</p>	<p>Services provided by BlueCard providers outside the service areas of the states listed in the column to the left, BlueCard providers in other states not listed, and any Out-of-Network/Non-Participating Provider.</p>
<p>Provider is responsible for Precertification.</p>	<ul style="list-style-type: none"> • Member is responsible for Precertification. • Member is financially responsible for service and/or setting that are not covered under this Plan based on an Adverse Determination of Medical Necessity or Experimental/Investigative.

Anthem will utilize its clinical coverage guidelines, such as medical policy, clinical guidelines, preventative care clinical coverage guidelines, and other applicable policies and procedures to assist in making Medical Necessity decisions. Anthem reserves the right to review and update these clinical coverage guidelines periodically. Your Employer’s Plan takes precedence over these guidelines.

You are entitled to receive, upon request and free of charge, reasonable access to any documents relevant to Your request. To request this information, contact the Customer Service telephone number on Your Identification Card.

Anthem may, from time to time, waive, enhance, modify or discontinue certain medical management processes (including utilization management, case management, and disease management) if in Anthem’s discretion, such change is in furtherance of the provision of cost effective, value based and/or quality services.

In addition, Anthem may select certain qualifying Providers to participate in a program that exempts them from certain procedural or medical management processes that would otherwise apply. Anthem 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 modify any such exemption with or without advance notice.

You may determine whether a Provider is participating in certain programs by contacting the customer service number on the back of your ID card.

Anthem also may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected under this program, then Anthem may use one or more clinical utilization management guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to this Plan's Members.

Request Categories:

- **Urgent** – A request for Precertification or Predetermination that in the opinion of the treating Provider or any Physician with knowledge of the Member's medical condition, could in the absence of such care or treatment, seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function or subject the Member to severe pain that cannot be adequately managed without such care or treatment.
- **Prospective** – A request for Precertification or Predetermination that is conducted prior to the service, treatment or admission.
- **Concurrent/Continued Stay Review** - A request for Precertification or Predetermination that is conducted during the course of treatment or admission.
- **Retrospective** - A request for Precertification that is conducted after the service, treatment or admission has occurred. Post Service Clinical Claims Review is also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication of payment.

Decision and Notification Requirements

Timeframes and requirements listed are based in general on federal regulations. You may call the telephone number on Your membership card for additional information.

	Days to File Appeal	Decision Time Frame
Prospective Appeals	You have 180 days to file a mandatory first level of appeal from the date of the adverse determination.	Expedited/Concurrent - Anthem will respond within 72 hours from request of appeal (specialty match).
	You have 60 days to file a voluntary second level of appeal from the date of the first level of appeal adverse determination.	Mandatory Level I - Anthem will respond within 30 calendar days from request of appeal (specialty match).
		Voluntary Level II – Anthem will respond within 30 calendar days from request of appeal.
Retrospective Appeals	You have 180 days to file a mandatory first level of appeal from the date of the adverse determination.	Anthem will respond within 30 calendar days from the request of appeal (specialty match)
	You have 60 days to file a voluntary second level of appeal from the date of the first level of appeal adverse determination.	Anthem will respond within 30 calendar days.
External Appeals		
External Appeals are voluntary. If the outcome of the mandatory first level appeal is adverse, you may be eligible for an independent External Review pursuant to federal law. To be eligible, the appeal must be regarding a medical judgment or rescission.		
	Days to File Appeal	Decision Time Frame
	You have four months to file a voluntary external appeal from the day the first level denial is received.	The Independent Review Organization (IRO) has 72 hours from receipt of the appeal from Anthem
	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 the internal appeal process.	The Independent Review Organization (IRO) has 45 days from receipt of the appeal from Anthem.

If additional information is needed to make a decision, Anthem will notify the requesting Provider and send written notification to You or Your authorized representative of the specific information necessary to complete the review. If Anthem does not receive the specific information requested or if the information is not complete by the timeframe identified in the written notification, a decision will be made based upon the information in Anthem's possession.

Anthem will provide notification of its decision in accordance with federal regulations.

Notification may be given by the following methods:

Verbal: oral notification given to the requesting provider via telephone or via electronic means if agreed to by the provider.

Written: mailed letter or electronic means including email and fax given to, at a minimum, the requesting provider and the Member or authorized Member representative.

Precertification does not guarantee coverage for or payment of the service or procedure reviewed. For benefits to be paid, on the date You receive service:

1. You must be eligible for benefits;
2. the service or surgery must be a Covered Service under Your Plan; and
3. the service cannot be subject to an exclusion under Your Plan

4. You must not have exceeded any applicable limits under Your Plan.

Health Plan Individual Case Management

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

Anthem's 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, Anthem will help You meet your identified health care needs. This is reached through contact and team work with You and/or your authorized representative, treating Doctor(s), and other Providers.

In addition, Anthem 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. Anthem will make any recommendation of alternate or extended benefits to the Plan on a case-by-case basis, if in Anthem's discretion the alternate or extended benefit is in the best interest of the Member and the Plan. 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, Anthem will notify You or your authorized representative in writing.

BENEFITS

Payment terms apply to all Covered Services. Please refer to the Schedule of Benefits for details. All Covered Services must be Medically Necessary, whether provided through Network Providers or Out-of-Network Providers.

Ambulance Service

Medically Necessary ambulance services are a Covered Service when one or more of the following criteria are met:

- 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.
- For ground ambulance, You are taken:
 - From your home, the scene of an accident or medical Emergency to a Hospital;
 - Between Hospitals, including when Anthem requires You to move from an Out-of-Network Hospital to a 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 Anthem requires You to move from an Out-of-Network Hospital to a Network Hospital
 - Between a Hospital and an approved Facility.

Ambulance services are subject to Medical Necessity reviews by Anthem. Emergency ambulance services do not require precertification and are allowed regardless of whether the Provider is a Network or Out-of-Network Provider.

Non-Emergency ambulance services are subject to Medical Necessity reviews by Anthem. When using an air ambulance, for non-Emergency transportation, Anthem reserves the right to select the air ambulance Provider. If you do not use the air ambulance Provider Anthem selects, the Out-of-Network Provider may bill you for any charges that exceed the Plan's Maximum Allowed Amount.

You must be taken to the nearest Facility that can give care for your condition. In certain cases Anthem 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, but are not limited to, 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 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.**

Assistant Surgery

Services rendered by an assistant surgeon are covered based on Medical Necessity.

Behavioral Health Care and Substance Abuse Treatment

See the Schedule of Benefits for any applicable Deductible, Coinsurance/Copayment information. Coverage for the diagnosis and treatment of Behavioral Health Care and Substance Abuse Treatment on an Inpatient or Outpatient basis will not be subject to Deductibles or Copayment/Coinsurance provisions that are less favorable than the Deductibles or Copayment/Coinsurance provisions that apply to a physical illness as covered under this Benefit Booklet.

Covered Services include the following:

- **Inpatient Services** in a Hospital or any Facility that we must cover by law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification.
- **Outpatient Services** including office visits and treatment in an outpatient department of a Hospital or outpatient Facility, such as partial hospitalization programs and intensive outpatient programs.
- **Residential Treatment** which is specialized 24-hour treatment in a licensed Residential Treatment Center. It offers individualized and intensive treatment and includes:
 - Observation and assessment by a psychiatrist weekly or more often,
 - Rehabilitation, therapy and education.
- **ADD/ADHD** includes Autistic Disease, Mental Retardation, Developmental Delays and Learning Disabilities. Respite Care is covered for Autism. Limited to \$4,500 per calendar year.

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

- Psychiatrist,
- Psychologist,
- 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.

If claiming Respite Care for Autism, Respite Care services do not need to be performed by a licensed provider. Instead, Respite Care services may be performed by a non-licensed Respite Caregiver provided the following qualifications/requirements are met:

- The non-licensed Respite Caregiver **MUST** be of legal age (18).
- The non-licensed Respite Caregiver must **NOT** live in the same home as the patient to be considered for payment reimbursement.
- Persons claiming payment reimbursement for Respite Care must complete a Respite Care Receipt Form, in addition to a medical claim form, provided by Anthem.

- The non-licensed Respite Caregiver MUST initial, sign and date the Respite Care Receipt Form.
- Primary Member MUST Sign and date the Respite Care Receipt Form, certifying that the information supplied on the form is true and accurate for the Respite Care services received.
- Primary Member may be asked to supply documentation of payment to the non-licensed Respite Caregiver

Breast Cancer Care

Covered Services are provided for Inpatient care following a mastectomy or lymph node dissection until the completion of an appropriate period of stay as determined by the attending Physician in consultation with the Member. Follow-up visits are also included and may be conducted at home or at the Physician's office as determined by the attending Physician in consultation with the Member.

Breast Reconstructive Surgery

Covered Services are provided following a mastectomy for reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications, including lymphedemas.

Cardiac Rehabilitation

Covered Services are provided as outlined in the **Schedule of Benefits**.

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 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 a 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 other requests for clinical trials services, including requests 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. The Plan reserves its right to exclude any of the following services

- i. The Experimental/Investigative item, device, or service, itself; or
- ii. Items and services that are provided 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.

Consultation Services

Covered when the special skill and knowledge of a consulting Physician is required for the diagnosis or treatment of an illness or Injury. Second surgical opinion consultations are covered.

Staff consultations required by Hospital rules are excluded. Referrals, the transfer of a patient from one Physician to another for treatment, are not consultations under this Plan.

Dental Services

Related to Accidental Injury

Your Plan includes benefits for dental work required for the initial repair of an Injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the Member's condition. Injury as a result of chewing or biting is not considered an Accidental Injury, except where the chewing or biting results from an act of domestic violence or directly from a medical condition.

Other Dental Services

Your Plan also includes benefits for Hospital charges and anesthetics provided for dental care if the Member meets any of the following conditions:

- The Member is under the age of five (5);
- The Member has a severe disability that requires hospitalization or general anesthesia for dental care; or
- The Member has a medical condition that requires hospitalization or general anesthesia for dental care.

Diabetes

Equipment and Outpatient self-management training and education, including nutritional therapy for individuals with insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes as prescribed by the Physician. Covered Services for Outpatient self-management training and education must be provided by a certified, registered or licensed health care professional with expertise in diabetes. Screenings for gestational diabetes are covered under "Preventive Care."

Dialysis Treatment

The Plan covers Covered Services for Dialysis treatment. If applicable, the Plan will pay secondary to Medicare Part B, even if a Member has not applied for eligible coverage available through Medicare.

Durable Medical Equipment

This Plan will pay the rental charge up to the purchase price of the equipment. In addition to meeting criteria for Medical Necessity, and applicable Precertification requirements, the equipment must also be used to improve the functions of a malformed part of the body or to prevent or slow further decline of the Member's medical condition. The equipment must be ordered and/or prescribed by a Physician and be appropriate for in-home use.

The equipment must meet the following criteria:

- It can stand repeated use;
- It is manufactured solely to serve a medical purpose;
- It is not merely for comfort or convenience;
- It is normally not useful to a person not ill or Injured;
- It is ordered by a Physician;
- The Physician certifies in writing the Medical Necessity for the equipment. The Physician also states the length of time the equipment will be required. The Plan may require proof at any time of the continuing Medical Necessity of any item;
- It is related to the Member's physical disorder.

Emergency Services

Life-threatening Medical Emergency or serious Accidental Injury.

Coverage is provided for Hospital emergency room care including a medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate an Emergency Medical Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to Stabilize the patient. Emergency Service care does not require any Prior Authorization from the Plan.

Stabilize means, with respect to an Emergency Medical Condition: to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility. With respect to a pregnant woman who is having contractions, the term "stabilize" also means to deliver (including the placenta), if there is inadequate time to effect a safe transfer to another Hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.

The Maximum Allowed Amount for emergency care from an Out-of-Network Provider will be the greatest of the following:

- The amount negotiated with Network Providers for the Emergency service furnished;
- The amount for the Emergency Service calculated using the same method Anthem generally uses to determine payments for Out-of-Network services but substituting the Network cost-sharing provisions for the Out-of-Network cost-sharing provisions; or
- The amount that would be paid under Medicare for the Emergency Service.

The Copayment and/or Coinsurance percentage payable for both Network and Out-of-Network are shown in the Schedule of Benefits.

General Anesthesia Services

Covered when ordered by the attending Physician and administered by another Physician who customarily bills for such services, in connection with a covered procedure.

Such anesthesia service includes the following procedures which are given to cause muscle relaxation, loss of feeling, or loss of consciousness:

- spinal or regional anesthesia;
- injection or inhalation of a drug or other agent (local infiltration is excluded).

Anesthesia services administered by a Certified Registered Nurse Anesthetist (CRNA) are only covered when billed by the supervising anesthesiologist.

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.

Home Health Care Services

Home Health Care provides a program for the Member's care and treatment in the home. Your coverage is outlined in the **Schedule of Benefits**. The program consists of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the Member's attending Physician. Services may be performed by either In-Network or Out-of-Network Providers.

Some special conditions apply:

- The Physician's statement and recommended program must be pre-certified.
- Claims will be reviewed to verify that services consist of skilled care that is medically consistent with the diagnosis. Note: Covered Services available under Home Health Care do NOT reduce Outpatient benefits available under the Physical Therapy section shown in this Plan.
- A Member must be essentially confined at home.

Covered Services:

- Visits by an RN or LPN. Benefits cannot be provided for services if the nurse is related to the Member.
- Visits by a qualified physiotherapist or speech therapist and by an inhalation therapist certified by the National Board of Respiratory Therapy.
- Visits to render services and/or supplies of a licensed Medical Social Services Worker when Medically Necessary to enable the Member to understand the emotional, social, and environmental factors resulting from or affecting the Member's illness.
- Visits by a Home Health Nursing Aide when rendered under the direct supervision of an RN.
- Nutritional guidance when Medically Necessary.
- Administration or infusion of prescribed drugs.
- Oxygen and its administration.

Covered Services for Home Health Care do not include:

- Food, housing, homemaker services, sitters, home-delivered meals.
- Home Health Care services which are not Medically Necessary or of a non-skilled level of care.
- Services and/or supplies which are not included in the Home Health Care plan as described.
- Services of a person who ordinarily resides in the Member's home or is a member of the family of either the Member or Member's Spouse.
- Any services for any period during which the Member is not under the continuing care of a Physician.
- Convalescent or Custodial Care where the Member has spent a period of time for recovery of an illness or surgery and where skilled care is not required or the services being rendered are only for aid in daily living, i.e., for the convenience of the Member.
- Any services or supplies not specifically listed as Covered Services.
- Routine care and/or examination of a newborn child.
- Dietician services.

- Maintenance therapy.
- Dialysis treatment.
- Purchase or rental of dialysis equipment.

Hospice Care Services

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 surviving Members of the immediate family for one year after the Member's death. Immediate family means your spouse, children, stepchildren, parents, brothers and sisters.

Your Doctor and Hospice medical director must certify that You are terminally ill and likely have less than 12 months to live. 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 Anthem upon request.

Benefits for Covered Services beyond those listed above, such as chemotherapy and radiation therapy given as palliative care, are available to a Member in Hospice. These additional Covered Services will be covered under other parts of this Benefit Booklet.

Hospital Services

You may receive treatment at a Network or an Out-of-Network Hospital. However, payment is significantly reduced if services are received at an Out-of-Network Hospital. Your Plan provides Covered Services when the following services are Medically Necessary.

Network

Inpatient Services

- Inpatient room charges. Covered Services include Semiprivate Room and board, general nursing care and intensive or cardiac care. If You stay in a private room, the Maximum Allowed Amount is based on the Hospital's prevalent Semiprivate rate. If You are admitted to a Hospital that has only private rooms, the Maximum Allowed Amount is based on the Hospital's prevalent room rate.

Service and Supplies

- Services and supplies provided and billed by the Hospital while You're an Inpatient, including the use of operating, recovery and delivery rooms. Laboratory and diagnostic examinations, intravenous solutions, basal metabolism studies, electrocardiograms, electroencephalograms, x-ray examinations, and radiation and speech therapy are also covered.
- Convenience items (such as radios, TV's, record, tape or CD players, telephones, visitors' meals, etc.) will not be covered.

Length of Stay

- Determined by Medical Necessity.

Out-of-Network

Hospital Benefits

If You are confined in an Out-of-Network Hospital, Your benefits will be significantly reduced, as explained in the “**Schedule of Benefits**” section.

Outpatient Hospital Services

The Plan provides Covered Services when the following Outpatient services are Medically Necessary: pre-admission tests, surgery, diagnostic X-rays and laboratory services. Certain procedures require Precertification.

Hospital Visits

The Physician’s visits to his or her patient in the Hospital. Covered Services are limited to one daily visit for each attending Physician specialty during the covered period of confinement.

Human Organ and Tissue Transplant Services

Notification

To maximize your benefits, You need to call Anthem’s transplant department to discuss benefit coverage when it is determined a transplant may be needed. You must do this before You have an evaluation and/or work-up for a transplant. Your evaluation and work-up services must be provided by a Network Transplant Provider to receive the maximum benefits.

Contact the customer service telephone number on Your Identification Card and ask for the transplant coordinator. Anthem will then assist the Member in maximizing their benefits by providing coverage information including details regarding what is covered and whether any medical policies, network requirements or benefit booklet exclusions are applicable. Failure to obtain this information prior to receiving services could result in increased financial responsibility for the Member.

Covered Transplant Benefit Period

Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the Network Transplant Provider agreement. Contact Anthem for specific Network Transplant Provider information for services received at or coordinated by a Network Transplant Provider Facility or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at an Out-of-Network Transplant Provider Facility.

Prior Approval and Precertification

In order to maximize Your benefits, Anthem strongly encourages You to call its’ transplant department to discuss benefit coverage when it is determined a transplant may be needed. You must do this before You have an evaluation and/or work-up for a transplant. Anthem will assist You in maximizing Your benefits by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, Network Transplant Provider requirements, or exclusions are applicable. Contact the Customer Service telephone number on the back of Your Identification Card and ask for the transplant coordinator. Even if Anthem issues a prior approval for the Covered Transplant Procedure, You or Your Provider must call Anthem’s Transplant Department for precertification prior to the transplant whether this is performed in an Inpatient or outpatient setting.

Please note that there are instances where Your Provider requests approval for Human Leukocyte Antigen (HLA) testing, donor searches and/or a collection and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing. 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 a collection and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

Transportation and Lodging

The Plan will provide assistance with reasonable and necessary travel expenses as determined by Anthem when You obtain prior approval and are required to travel more than 75 miles from Your residence to reach the facility where Your covered transplant procedure will be performed. The Plan's assistance with travel expenses includes transportation to and from the facility and lodging for the transplant recipient Member and one companion for an adult Member, or two companions for a child patient. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to Anthem when claims are filed. Contact Anthem for detailed information. Anthem will follow Internal Revenue Service (IRS) guidelines in determining what expenses can be paid.

Licensed Speech Therapist Services

Services must be ordered and supervised by a Physician as outlined in the **Schedule of Benefits**.

Maternity Care and Reproductive Health Services

Covered Services are provided for Network Maternity Care subject to the benefit stated in the **Schedule of Benefits**. If You choose an Out-of-Network Provider, benefits are subject to the Deductible and percentage payable provisions as stated in the **Schedule of Benefits**.

Routine newborn nursery care is part of the mother's maternity benefits. Benefits are provided for well-baby pediatrician visits performed in the Hospital.

Should the newborn require other than routine nursery care, the baby will be admitted to the Hospital in his or her own name. (See "Changing Coverage (Adding a Dependent)" to add a newborn to Your coverage.)

Under federal law, the Plan may not restrict the length of stay to less than the 48/96 hour periods or require Precertification for either length of stay. The length of hospitalization which is Medically Necessary will be determined by the Member's attending Physician in consultation with the mother. Should the mother or infant be discharged before 48 hours following a normal delivery or 96 hours following a cesarean section delivery, the Member will have access to two post-discharge follow-up visits within the 48 or 96 hour period. These visits may be provided either in the Physician's office or in the Member's home by a Home Health Care Agency. The determination of the medically appropriate place of service and the type of provider rendering the service will be made by the Member's attending Physician.

Abortion (Therapeutic and Elective) - Your Plan includes benefits for a therapeutic abortion, which is an abortion recommended by a Provider that is performed to save the life or health of the mother. Your Plan **does not** provide benefits for an elective (voluntary) abortion, which is an abortion performed for reasons other than those described above.

Contraceptive Benefits

Benefits include oral contraceptive Drugs, injectable contraceptive Drugs and patches. Benefits also 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. Certain contraceptive benefits are covered under the prescription Summary Plan Description.

Infertility Services

Your Plan also includes benefits for the diagnosis of Infertility.

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.

Medical Care

General diagnostic care and treatment of illness or Injury. Some procedures require Precertification.

Nutritional Counseling

Nutritional counseling related to the medical management of a disease state as stated in the Schedule of Benefits.

Out-of-Network Freestanding Ambulatory Facility

Any services rendered or supplies provided while You are a patient or receiving services at or from an Out-of-Network Freestanding Ambulatory Facility will be payable at the Maximum Allowed Amount.

Out-of-Network Hospital Benefits

If You are confined in an Out-of-Network Hospital, Your benefits will be significantly reduced, as explained in the "**Schedule of Benefits**" section.

Obesity

Surgical treatment of obesity is only covered for patients meeting Medical Necessity criteria, as defined by the Plan.

Online Visits

When available in Your area, Your coverage will include online visits from a LiveHealth Online Provider. Covered Services include a medical consultation using the internet via a webcam, chat or voice. See Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment and benefit limitation information. Online visits are not covered from Providers other than those contracted with LiveHealth Online. Non Covered Services include, but are not limited to communications used for:

- Reporting normal lab or other test results;
- Office appointment requests;
- Billing, insurance coverage or payment questions;
- Requests for referrals to Physicians outside the online care panel;
- Benefit precertification;
- Physician to Physician consultation.

Oral Surgery

Covered Services include only the following:

- Fracture of facial bones;
- Removal of impacted teeth;
- Lesions of the mouth, lip, or tongue which require a pathological exam;
- Incision of accessory sinuses, mouth salivary glands or ducts;
- Dislocations of the jaw;
- Treatment of temporomandibular joint syndrome (TMJ) or myofascial pain and related surgery and diagnostic services.
- Covered Services do **not** include operative restoration of teeth (fillings), or prosthetics (crowns, bridges, dentures)

Although this Plan covers certain oral surgeries as listed above, many oral surgeries are not covered. Covered Services also include the following:

- 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” 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.

Other Covered Services

Your Plan provides Covered Services when the following services are Medically Necessary:

- Chemotherapy and radioisotope, radiation and nuclear medicine therapy
- Diagnostic x-ray and laboratory procedures
- Dressings, splints, casts when provided by a Physician
- Oxygen, blood and components, and administration
- Pacemakers and electrodes
- Use of operating and treatment rooms and equipment

Outpatient CT Scans and MRIs

These services are covered at regular Plan benefits.

Outpatient Surgery

Network Hospital Outpatient department or Network Freestanding Ambulatory Facility charges are covered at regular Plan benefits. Benefits for treatment by an Out-of-Network Hospital are explained under “Hospital Services”.

Physical Therapy, Occupational Therapy, Chiropractic Care

Services by a Physician, a registered physical therapist (R.P.T.), a licensed occupational therapist (O.T.), or a licensed chiropractor (D.C.) as outlined in the **Schedule of Benefits**. All services rendered must be within the lawful scope of practice of, and rendered personally by, the individual Provider.

Physician Services

You may receive treatment from a Network or Out-of-Network Physician. However, payment is significantly reduced if services are received from an Out-of-Network Physician. Such services are subject to Your Deductible and Out-of-Pocket requirements.

Preventive Care – Well Child/Well Adult Care

Preventive care services include screenings and other services for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service.

Members who have current symptoms or have been diagnosed with a medical condition are not considered to require Preventive Care for that condition but instead benefits will be considered under the Diagnostic Services benefit.

Preventive Care Services in this section shall meet requirements as determined by federal and state law. Many preventive care services are covered by this Plan with no Deductible, Copayments or Coinsurance from the Member when provided by a Network Provider. That means the Plan pays 100% of the Maximum Allowed Amount. These services fall under the following broad categories as shown below:

1. Services with an “A” or “B” rating from the United States Preventive Services Task Force.
Examples of these services are screenings for:
 - a. Breast cancer;
 - b. Cervical cancer;
 - c. Colorectal cancer;
 - 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 provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
 - a. Women’s contraceptives, sterilization procedures, and counseling. Coverage includes contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants.
 - b. Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per pregnancy.
 - c. Gestational diabetes screening.

You may call Customer Service using the number on Your ID card for additional information about these services or view the federal government’s web sites, <http://www.healthcare.gov/center/regulations/prevention.html>, <http://www.ahrq.gov>, and <http://www.cdc.gov/vaccines/acip/index.html>.)

Prosthetic Appliances

Prosthetic devices to improve or correct conditions resulting from Accidental Injury or illness are covered if Medically Necessary and ordered by a Physician.

Prosthetic devices include: artificial limbs and accessories; artificial eyes, one pair of glasses or contact lenses for eyes used after surgical removal of the lens(es) of the eye(s); arm braces, leg braces (and attached shoes); and external breast prostheses used after breast removal.

The following items are excluded: corrective shoes; dentures; replacing teeth or structures directly supporting teeth, except to correct traumatic Injuries; electrical or magnetic continence aids (either anal or urethral); and implants for cosmetic purposes except for reconstruction following a mastectomy.

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. Reconstructive services needed as a result of an earlier treatment are covered only if the first treatment would have been a Covered Service under this Plan.

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

Retail Health Clinic

Benefits are provided for Covered Services received at a Retail Health Clinic.

Skilled Nursing Facility Care

Benefits are provided as outlined in the **Schedule of Benefits**. This care must be ordered by the attending Physician. All Skilled Nursing Facility admissions must be pre-certified. Claims will be reviewed to verify that services consist of Skilled Convalescent Care that is medically consistent with the diagnosis.

Skilled Convalescent Care during a period of recovery is characterized by:

- a favorable prognosis;
- a reasonably predictable recovery time; and
- services and/or facilities less intense than those of the acute general Hospital, but greater than those normally available at the Member's residence.

Covered Services include:

- semi-private or ward room charges including general nursing service, meals, and special diets. If a Member stays in a private room, this Plan pays the Semiprivate Room rate toward the charge for the private room;
- use of special care rooms;
- pathology and radiology;
- physical or speech therapy;
- oxygen and other gas therapy;
- drugs and solutions used while a patient; or
- gauze, cotton, fabrics, solutions, plaster and other materials used in dressings, bandages, and casts.

This benefit is available only if the patient requires a Physician's continuous care and 24-hour-a-day nursing care.

Benefits will not be provided when:

- A Member reaches the maximum level of recovery possible and no longer requires other than routine care;
- Care is primarily Custodial Care, not requiring definitive medical or 24-hour-a-day nursing service;
- Care is for mental illness including drug addiction, chronic brain syndromes and alcoholism, and no specific medical conditions exist that require care in a Skilled Nursing Facility;
- A Member is undergoing senile deterioration, mental deficiency or retardation, and has no medical condition requiring care;
- The care rendered is for other than Skilled Convalescent Care.

Surgical Care

Surgical procedures including the usual pre- and post-operative care. Some procedures require Precertification.

Treatment of Accidental Injury in a Physician's Office

All Outpatient surgical procedures related to the treatment of an Accidental Injury, when provided in a Physician's office, will be covered under the Member's Physician's office benefit if services are rendered by a Network Provider; services rendered by Out-of-Network Providers are subject to Deductible and Coinsurance requirements.

Prescription Drugs Administered by a Medical Provider

This Plan covers Prescription Drugs when they are administered to You as part of a doctor's visit, home care visit, or at an outpatient Facility. This includes Drugs for infusion therapy, chemotherapy, Specialty Drugs, blood products, and injectables and any drug that must be administered by a Provider. This section applies when Your Provider orders the Drug and administers it to You. Benefits for Drugs that You inject or get at a Pharmacy (i.e., self-administered Drugs) are not covered under this section.

Benefits for those Drugs are described in the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order)” Pharmacy section.

Note: When Prescription Drugs are covered under this benefit, they will not also be covered under your Employer’s Prescription Drug Plan. Also, if Prescription Drugs are covered under your Employer’s Prescription Drug Plan they will not be covered under this benefit.

Important Details About Prescription Drug Coverage

Your Plan includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, your prescribing Provider may be asked to give more details before Anthem can determine if the Drug is Medically Necessary. Anthem may also set quantity and/or age limits for specific Prescription Drugs or use recommendations made as part of its Medical Policy and Technology Assessment Committee and/or Pharmacy and Therapeutics Process.

Prior Authorization

Prior authorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. Anthem will contact your Provider to get the details Anthem needs to decide if prior authorization should be given. Anthem will give the results of its decision to both You and your Provider.

If prior authorization is denied You have the right to file a Grievance as outlined in the “Your Right to Appeal” section.

For a list of Drugs that need prior authorization, please call the phone number on the back of your Identification Card. The list will be reviewed and updated from time to time. Including a Drug or related item on the list does not guarantee coverage under this Plan. Your Provider may check with Anthem to verify Drug coverage, to find out whether any quantity (amount) and/or age limits apply, and to find out which brand or generic Drugs are covered under the Plan.

Step Therapy

Step therapy is a process in which You may need to use one type of Drug before Anthem will cover another. Anthem checks certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help You get high quality and cost effective Prescription Drugs. If a Provider decides that a certain Drug is needed, prior authorization will apply.

Therapeutic Substitution

Therapeutic substitution is an optional program that tells You and your Providers about alternatives to certain prescribed Drugs. Anthem may contact You and your Provider to make You aware of these choices. Only You and your Provider can determine if the therapeutic substitute is right for You. Anthem has a therapeutic Drug substitutes list, which Anthem reviews and updates from time to time. For questions or issues about therapeutic Drug substitutes, call Customer Service at the phone number on the back of your Identification Card.

LIMITATIONS AND EXCLUSIONS

1. Any disease or Injury resulting from a war, declared or not, or any military duty or any release of nuclear energy. Also excluded are charges for services directly related to military service provided or available from the Veterans' Administration or military facilities except as required by law.
2. Services for Custodial Care.
3. Services for custodial or convalescent care, rest cures or long-term custodial Hospital care.
4. Dental care and treatment and oral surgery (by Physicians or dentists) including dental surgery; dental appliances; dental prostheses such as crowns, bridges, or dentures; implants; orthodontic care; operative restoration of teeth (fillings); dental extractions; endodontic care; apicoectomies; excision of radicular cysts or granuloma; treatment of dental caries, gingivitis, or periodontal disease by gingivectomies or other periodontal surgery. Any treatment of teeth, gums or tooth related service except otherwise specified as covered in this Benefit Booklet.
5. Charges for treatment received before coverage under this option began or after it is terminated.
6. Treatments, procedures, equipment, drugs, devices or supplies (hereafter called "services") which are, in Anthem's judgment, Experimental or Investigational for the diagnosis for which the Member is being treated.
7. Services, treatment or supplies not generally accepted in medical practice for the prevention, diagnosis or treatment of an illness or injury, as determined by Anthem.
8. Foot care only to improve comfort or appearance, routine care of corns, calluses, toenail (except surgical removal or care rendered as treatment of the diabetic foot or ingrown toenails), flat feet, fallen arches, weak feet, chronic foot strain, or asymptomatic complaints related to the feet. Coverage is available, however, for Medically Necessary foot care required as part of the treatment of diabetes and for Members with impaired circulation to the lower extremities.
9. Shoe inserts, orthotics (will be covered if prescribed by a physician for diseases of the foot or systemic diseases that affect the foot such as diabetes when deemed medically necessary).
10. Treatment where payment is made by any local, state, or federal government (except Medicaid), or for which payment would be made if the Member had applied for such benefits. Services that can be provided through a government program for which You as a member of the community are eligible for participation. Such programs include, but are not limited to, school speech and reading programs.
11. Services paid under Medicare or which would have been paid if the Member had applied for Medicare and claimed Medicare benefits. With respect to end-stage renal disease (ESRD), Medicare shall be treated as the primary payor whether or not the Participant has enrolled in Medicare Part B.
12. Services covered under Workers' Compensation, no-fault automobile insurance and/or services covered by similar statutory programs.
13. Court-ordered services, or those required by court order as a condition of parole or probation, unless Medically Necessary and approved by the Plan.
14. Outpatient prescription drugs prescribed by a physician and purchased or obtained from a retail pharmacy or retail pharmacist or a mail service pharmacy are excluded. These may be covered by your prescription drug program but not under this medical plan. Although coverage for Outpatient Prescription Drugs obtained from a retail pharmacy or pharmacist or mail service Pharmacy is excluded, certain Prescription Drugs are covered under your medical benefits when rendered in a

Hospital, in a Physician's office, or as part of a Home Health Care benefit. Therefore, this exclusion does not apply to prescription drugs provided as Ancillary Services during an Inpatient stay or an Outpatient Surgical procedure; to prescription drugs used in conjunction with a Diagnostic Service; Chemotherapy performed in the office; home infusion or home IV therapy, nor drugs administered in your Physician's office.

15. Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug, device, product, or supply.
16. Care, supplies, or equipment not Medically Necessary, as determined by Anthem, for the treatment of an Injury or illness. This includes, but is not limited to, care which does not meet Anthem's medical policy, clinical coverage guidelines, or benefit policy guidelines.
17. Vitamins, minerals and food supplements, as well as vitamin injections not determined to be medically necessary in the treatment of a specific illness. Nutritional supplements, services, supplies and/or nutritional sustenance products (food) related to enteral feeding, except when determined to be medically necessary.
18. Services for Hospital confinement primarily for diagnostic studies.
19. Cosmetic Surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of, or as a result of, Cosmetic Surgery, except for reconstructive surgery following a mastectomy or when medically necessary to correct damage caused by an accident, an injury or to correct a congenital defect. Expense incurred for reconstructive surgery performed due to the presence of a psychological condition is not covered, unless the condition(s) described above are met.
20. Donor Search/Compatibility, except as otherwise indicated.
21. Contraceptive drugs, except for any above stated covered contraceptive devices.
22. In-vitro Fertilization, Artificial Insemination and as indicated on the Plan Design. Any other infertility services other than services necessary for the diagnosis of infertility.
23. Hair transplants, hairpieces or wigs (except when necessitated by disease), wig maintenance, or prescriptions or medications related to hair growth.
24. Services and supplies primarily for educational, vocational or training purposes, including but not limited to structured teaching, applied behavioral analysis, or educational interventions, except as expressly provided in this Benefit Booklet.
25. Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling and sex therapy.
26. Christian Science practitioner services.
27. Services and supplies for smoking cessation programs and treatment of nicotine addiction, including gum, patches, and prescription drugs to eliminate or reduce the dependency on or addiction to tobacco and tobacco products unless otherwise required by law. Refer to your prescription Summary Plan Description or contact KEHP for information on tobacco cessation programs.
28. Services provided in a halfway house.
29. Treatment or services provided by a non-licensed Provider, or that do not require a license to provide; services that consist of supervision by a Provider of a non-licensed person; services performed by a relative of a Member for which, in the absence of any health benefits coverage, no charge would be made; services provided to the Member by a local, state or federal government agency, or by a public school system or school district, except when the plan's benefits must be provided by law; services if the Member is not required to pay for them or they are provided to the Member for free.
30. Elective Abortions.

31. Any expense incurred for services received outside of the United States, except for emergency care services, unless otherwise determined by this Plan;
32. Acupuncture and biofeedback.
33. Routine care is not covered. Except for above stated covered preventive care services.
34. Services or supplies provided by a member of your family or household.
35. Charges or any portion of a charge in excess of the Maximum Allowed Amount as determined by Anthem.
36. Fees or charges made by an individual, agency or facility operating beyond the scope of its license.
37. Services and supplies for which you have no legal obligation to pay, or for which no charge has been made or would be made if you had no health insurance coverage.
38. Services for any form of telecommunication. Except for above stated covered online services.
39. Charges for any of the following:
 - a. Failure to keep a scheduled visit;
 - b. Completion of claim forms or medical records or reports unless otherwise required by law;
 - c. For Physician or Hospital's stand-by services;
 - d. For holiday or overtime rates.
 - e. Membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.
 - f. Specific medical reports including those not directly related to the treatment of the Member, e.g., employment or insurance physicals, and reports prepared in connection with litigation.
40. Separate charges by interns, residents, house Physicians or other health care professionals who are employed by the covered facility, which makes their services available.
41. Personal comfort items such as those that are furnished primarily for your personal comfort or convenience, including those services and supplies not directly related to medical care, such as guest's meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, and take-home supplies.
42. Charges for or related to sex change surgery or to any treatment of gender identity disorders.
43. Reversal of vasectomy or reversal of tubal ligation.
44. Salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, and actinic changes and/or which are performed as a treatment for acne.
45. Services for outpatient therapy or rehabilitation other than those specifically listed as covered in this Benefit Booklet. Excluded forms of therapy include, but are not limited to, primal therapy, chelation therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, in-home wrap around treatment, wilderness therapy and boot camp therapy.
46. Vision care services and supplies, including but not limited to eyeglasses, contact lenses and related or routine examinations and services. Eye refractions. Analysis of vision or the testing of its acuity. Service or devices to correct vision or for advice on such service. Orthoptic training is not covered. This exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery or for soft contact lenses due to a medical condition, i.e. diabetes.
47. Related to radial keratotomy or keratomileusis or excimer laser photo refractive keratectomy; and surgery, services or supplies for the surgical correction of nearsightedness and/or astigmatism or any other correction of vision due to a refractive problem.

48. Services for weight loss programs, services and supplies. Weight loss programs included but are not limited to, commercial weight loss programs (Weight Watcher, Jenny Craig, and LA Weight Loss). Contact KEHP for information regarding a weight loss program(s) available to Members.
49. Surgical procedures for the removal of excess fat and/or skin in conjunction with or resulting from weight loss due to obesity, surgery, or pregnancy. Services, supplies, or other care for abdominoplasty, panniculectomy, Liposuction/Lipectomy, Skin-Related Procedures.
50. TMJ Appliances – fixed or removable appliances which involve movement or repositioning of the teeth.

CLAIMS PAYMENT

Network Providers have agreed to submit claims directly to the local Blue Cross and/or Blue Shield plan in their area. Therefore if the Network Hospitals, Physicians and Ancillary Providers are used, claims for their services will generally not have to be filed by the Member. In addition, many Out-of-Network Hospitals and Physicians will also file claims if the information on the Blue Cross and Blue Shield Identification Card is provided to them. If the provider requests a claim form to file a claim, a claim form can be obtained by contacting Your local Human Resources Department or by visiting www.anthem.com.

Please note You may be required to complete an authorization form in order to have Your claims and other personal information sent to Anthem when You receive care in foreign countries. Failure to submit such authorizations may prevent foreign providers from sending Your claims and other personal information to Anthem.

How to File Claims

Under normal conditions, Anthem should receive the proper claim form within 12 months after the service was provided. This section of the Benefit Booklet describes when to file a benefits claim and when a Hospital or Physician will file the claim for You.

Each person enrolled through the Plan receives an Identification Card. Remember, in order to receive full benefits, You must receive treatment from a Network Provider. When admitted to a Network Hospital, present Your Identification Card. Upon discharge, You will be billed only for those charges not covered by the Plan.

When You receive Covered Services from a Network Physician or other Network licensed health care provider, ask him or her to complete a claim form. Payment for Covered Services will be made directly to the provider.

For health care expenses other than those billed by a Network Provider, use a claim form to report Your expenses. You may obtain these from Your Employer or Anthem. Claims should include Your name, Plan and Group numbers exactly as they appear on Your Identification Card. Attach all bills to the claim form and file directly with Anthem. Be sure to keep a photocopy of all forms and bills for Your records. The address is on the claim form.

Save all bills and statements related to Your illness or Injury. Make certain they are itemized to include dates, places and nature of services or supplies.

Maximum Allowed Amount

General

This section describes how Anthem determines the amount of reimbursement for Covered Services. Reimbursement for services rendered by Network and Out-of-Network Providers is based on this Plan's Maximum Allowed Amount for the Covered Service that You receive. Please see the Inter-Plan Programs section for additional information.

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

- that meet Our 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 Plan.

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. In addition, 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.

When You receive Covered Services from a Provider, Anthem 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 Anthem's determination of the Maximum Allowed Amount. Anthem's application of these rules does not mean that the Covered Services You received were not Medically Necessary. It means Anthem has 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 Physician 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 a Network Provider or an Out-of-Network Provider.

A 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 Anthem. For Covered Services performed by a Network Provider, the Maximum Allowed Amount for this Plan is the rate the Provider has agreed with Anthem to accept as reimbursement for the Covered Services. Because 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 Customer Service for help in finding a Network Provider or visit www.anthem.com.

Providers who have not signed any contract with Anthem and are not in any of Anthem's networks are Out-of-Network Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

For Covered Services You receive from an Out-of-Network Provider, the Maximum Allowed Amount for this Plan will be one of the following as determined by Anthem:

1. An amount based on Anthem's Out-of-Network Provider fee schedule/rate, which Anthem has established in its' discretion, and which Anthem reserves 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 Anthem, 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, the Administrator 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 Anthem 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 contracted for other products with Anthem are also considered Out-of-Network. For this Plan, the Maximum Allowed Amount for services from these Providers will be one of the five methods shown above unless the contract between Anthem and that Provider specifies a different amount.

Unlike Network Providers, Out-of-Network Providers may send You a bill and collect for the amount of the Provider's charge that exceeds the Plan's Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing a Network Provider will likely result in lower Out of Pocket costs to You. Please call Customer Service for help in finding a Network Provider or visit Anthem's website at www.anthem.com.

Customer Service is also available to assist You in determining this Plan's Maximum Allowed Amount for a particular service from an Out-of-Network Provider. In order for Anthem 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 Customer Service 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).

Your cost share amount and Out-of-Pocket Limits may vary depending on whether You received services from a Network or Out-of-Network Provider. Specifically, You may be required to pay higher cost sharing amounts or may have limits on Your benefits when using Out-of-Network Providers. Please see the Schedule of Benefits in this Benefit Booklet for Your cost share responsibilities and limitations, or call Customer Service to learn how this Plan's benefits or cost share amounts may vary by the type of Provider You use.

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 a Network or Out-of-Network Provider. Non-Covered Services include services specifically excluded from coverage by the terms of this Benefit Booklet and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits.

In some instances You may only be asked to pay the lower Network cost sharing amount when You use an Out-of-Network Provider. For example, if You go to a Network Hospital or Provider facility and receive Covered Services from an Out-of-Network Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with a Network Hospital or facility, You will pay the Network cost share amounts for those Covered Services. However, You also may be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge.

Authorized Services

In some circumstances, such as where there is no Network Provider available for the Covered Service, the Plan may authorize the 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

circumstance, You must contact Anthem in advance of obtaining the Covered Service. The Plan also may authorize the Network cost share amounts to apply to a claim for Covered Services if You receive Emergency services from an Out-of-Network Provider and are not able to contact Anthem until after the Covered Service is rendered. If the Plan authorizes a Network cost share amount to apply to a Covered Service received from an Out-of-Network Provider, You also may still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please contact Customer Service for Authorized Services information or to request authorization.

Services Performed During Same Session

The Plan may combine the reimbursement of Covered Services when more than one service is performed during the same session. Reimbursement is limited to the Plan's Maximum Allowed Amount. If services are performed by Out-of-Network Providers, then You are responsible for any amounts charged in excess of the Plan's Maximum Allowed Amount with or without a referral or regardless if allowed as an Authorized Service. Contact Anthem for more information.

Processing Your Claim

You are responsible for submitting Your claims for expenses not normally billed by and payable to a Hospital or Physician. Always make certain You have Your Identification Card with You. Be sure Hospital or Physician's office personnel copy Your name, and identification numbers (including the 3-letter prefix) accurately when completing forms relating to Your coverage.

Timeliness of Filing for Member Submitted Claims

To receive benefits, a properly completed claim form with any necessary reports and records must be filed by You within 12 months of the date of service. Payment of claims will be made as soon as possible following receipt of the claim, unless more time is required because of incomplete or missing information. In this case, You will be notified of the reason for the delay and will receive a list of all information needed to continue processing Your claim. After this data is received, Anthem will complete claims processing. No request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

Necessary Information

In order to process Your claim, Anthem may need information from the provider of the service. As a Member, You agree to authorize the Physician, Hospital, or other provider to release necessary information.

Anthem will consider such information confidential. However, the Plan and Anthem have the right to use this information to defend or explain a denied claim.

Claims Review

Anthem has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking services from Out-of-Network Providers could be balanced billed by the Out-of-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

Explanation of Benefits

After You receive medical care, You will generally receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage You receive. The EOB is not a bill, but a statement sent by Anthem, to help You understand the coverage You are receiving. The EOB shows:

- total amounts charged for services/supplies received;
- the amount of the charges satisfied by Your coverage;

- the amount for which You are responsible (if any); and
- general information about Your Appeals rights and for ERISA plans, information regarding the right to bring an action after the Appeals process.

Inter-Plan Programs

Out-of-Area Services

Anthem has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as “Inter-Plan Programs.” Whenever You obtain healthcare services outside of Anthem’s service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between Anthem and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside Anthem’s service area, You will obtain care from healthcare Providers that have a contractual agreement (i.e., are “participating providers”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Blue”). In some instances, You may obtain care from nonparticipating healthcare Providers. Anthem’s payment practices in both instances are described below.

BlueCard® Program

Under the BlueCard® Program, when You access covered healthcare services within the geographic area served by a Host Blue, Anthem will remain responsible for fulfilling Anthem’s contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare Providers.

Whenever You access covered healthcare services outside Anthem’s service area and the claim is processed through the BlueCard Program, the amount You pay for covered healthcare services is calculated based on the lower of:

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

Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host Blue pays to Your healthcare Provider. Sometimes, it is an estimated price that takes into account special arrangements with Your healthcare Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Anthem uses for Your claim because they will not be applied retroactively to claims already paid.

Federal law or the laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, Anthem would then calculate your liability for any covered healthcare services according to applicable law.

You will be entitled to benefits for healthcare services that You accessed either inside or outside the geographic area Anthem serves, if this Booklet covers those healthcare services. Due to variations in Host Blue network protocols, You may also be entitled to benefits for some healthcare services obtained outside the geographic area Anthem serves, even though You might not otherwise have been entitled to benefits if You had received those healthcare services inside the geographic area Anthem serves. But in no event will You be entitled to benefits for healthcare services, wherever You received them that are specifically excluded from, or in excess of the limits of, coverage provided by this Plan.

Non-Participating Healthcare Providers Outside Anthem's Service Area

Member Liability Calculation

When covered healthcare services are provided outside of Anthem's Service Area by non-participating healthcare providers, the amount You pay for such services will generally be based on either the Host Blue's nonparticipating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, You may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment Anthem will make for the Covered Services as set forth in this paragraph.

Exceptions

In certain situations, Anthem may use other payment bases, such as billed covered charges, the payment the Administrator would make if the healthcare services had been obtained within Anthem's Service Area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount the Administrator will pay for services rendered by nonparticipating healthcare providers. In these situations, You may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment Anthem will make for the Covered Services as set forth in this paragraph.

If You obtain services in a state with more than one Blue Plan network, an exclusive network arrangement may be in place. If You see a Provider who is not part of an exclusive network arrangement, that Provider's service(s) will be considered Out-of-Network care, and You may be billed the difference between the charge and the Maximum Allowable Amount. You may call the Customer Service number on Your ID card or go to www.anthem.com for more information about such arrangements.

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. Fraudulent statements on enrollment forms and/or claims for services or payment involving all media (paper or electronic) may invalidate any payment or claims for services and be grounds for voiding the Member's coverage. This includes fraudulent acts to obtain medical services and/or Prescription Drugs.

Assignment

You authorize Anthem, on behalf of the Employer, to make payments directly to Providers for Covered Services. Anthem also reserves the right to make payments directly to You. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims, an Alternate Recipient, or that person's custodial parent or designated representative. Any payments made by Anthem will discharge the Employer's obligation to pay for Covered Services. You cannot assign Your right to receive payment to anyone else, except as required by a "Qualified Medical Child Support Order" as defined by ERISA or any applicable Federal law.

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

The coverage and any benefits under the Plan are not assignable by any Member without the written consent of the Plan, except as provided above.

Questions About Coverage or Claims

If You have questions about Your coverage, contact Your Plan Administrator or Anthem's Customer Service Department. Be sure to always give Your Member Identification number.

When asking about a claim, give the following information:

- identification number;
- patient's name and address;
- date of service and type of service received; and
- Provider name and address (Hospital or Physician).

To find out if a Hospital or Physician is a Network Provider, call them directly or call Anthem

The Plan does not supply You with a Hospital or Physician. In addition, neither the Plan nor Anthem is responsible for any injuries or damages You may suffer due to actions of any Hospital, Physician or other person. In order to process Your claims, Anthem or the Plan Administrator may request additional information about the medical treatment You received and/or other group health insurance You may have. This information will be treated confidentially.

An oral explanation of Your benefits by an employee of Anthem, Plan Administrator or Plan Sponsor is not legally binding.

Any correspondence mailed to You will be sent to Your most current address. You are responsible for notifying the Plan Administrator or Anthem of Your new address.

YOUR RIGHT TO APPEAL

The Plan wants your experience 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 Customer Service by calling the number on the back of Your ID card. Anthem will try to resolve Your complaint informally by talking to Your Provider or reviewing Your claim. If You are not satisfied with the resolution of your complaint, You have the right to file an Appeal, which is defined as follows:

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 Anthem 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, Anthem’s 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 Anthem’s 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 if You 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; and
- 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.
- the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist You

For claims involving urgent/concurrent care:

- Anthem’s notice will also include a description of the applicable urgent/concurrent review process; and
- Anthem 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. Anthem’s 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.

- Anthem 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 Anthem to complete its 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 Anthem's decision, can be sent between Anthem 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 Anthem 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, Georgia 30348

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

Upon request, Anthem 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.

Anthem 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, Anthem 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 Anthem considers Your appeal, Anthem 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, Anthem 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, Anthem 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, Anthem will notify You of the outcome of the appeal within 30 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 Anthem will include all of the information set forth in the above section entitled "Notice of Adverse Benefit Determination."

Voluntary Second Level Appeals

If You are dissatisfied with the Plan's 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.

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 Anthem within four (4) months of the notice of Your final internal adverse determination.

A request for an External Review must be in writing unless Anthem determines 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 Anthem's internal appeal process. You or Your authorized representative may request it orally or in writing. All necessary information, including Anthem's decision, can be sent between Anthem and You by telephone, facsimile or other similar method. To proceed with an Expedited External Review, You or Your authorized representative must contact Anthem 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 Anthem determines 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, Georgia 30348

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 three years 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 Plan's 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.

Anthem reserves 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.

COORDINATION OF BENEFITS (COB)

This Coordination of Benefits (COB) provision applies when You have health care coverage under more than one Plan.

Please note that several terms specific to this provision are listed below. Some of these terms have different meanings in other parts of the Benefit Booklet, e.g., Plan. For this provision only, "Plan" will have the meanings as specified below. In the rest of the Benefit Booklet, Plan has the meaning listed in the **Definitions** section.

The order of benefit determination rules determine the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to its policy terms regardless of the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

The Allowable expense under COB is generally the higher of the Primary and Secondary Plans' allowable amounts. A Network Provider can bill You for any remaining Coinsurance, Deductible and/or Copayment under the higher of the Plans' allowable amounts. This higher allowable amount may be more than the Plan's Maximum Allowable Amount.

COB DEFINITIONS

Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1. Plan includes: Group and non-group insurance contracts and subscriber contracts; Health maintenance organization (HMO) contracts; Uninsured arrangements of group or group-type coverage; Coverage under group or non-group closed panel plans; Group-type contracts; Medical care components of long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts (whether "fault" or "no fault"); Other governmental benefits, except for Medicare, Medicaid or a government plan that, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.
2. Plan does not include: Accident only coverage; Specified disease or specified accident coverage; Limited health benefit coverage; Benefits for non-medical components of long term care policies; Hospital indemnity coverage benefits or other fixed indemnity coverage; School accident-type coverages covering grammar, high school, and college students for accidents only, including athletic injuries, either on a twenty-four (24) hour or "to and from school" basis; and Medicare supplement policies.

Each contract for coverage under items 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan means the part of the contract providing health care benefits that the COB provision applies to and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when You have health care coverage under more than one Plan.

When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

Allowable expense is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering You. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering You is not an Allowable expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging You is not an Allowable expense; however, if a Provider has a contractual agreement with both the Primary and Secondary Plans, then the higher of the contracted fees is the Allowable expense, and the Provider may charge up to the higher contracted fee.

The following are non-Allowable expenses:

1. The difference between the cost of a semi-private Hospital room and a private Hospital room is not an Allowable expense, unless one of the Plans provides coverage for private Hospital room expenses.
2. If You are covered by 2 or more Plans that calculate their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement methods, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
3. If You are covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
4. If You are covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement will be the Allowable expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment will be the Allowable expense used by the Secondary Plan to determine its benefits.
5. The amount that is subject to the Primary high-Deductible health plan's Deductible, if Anthem has 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.

Closed panel plan is a Plan that provides health care benefits primarily in the form of services through a panel of Providers that contract with or are employed by the Plan, and that excludes coverage for services provided by other Providers, except in cases of emergency or referral by a panel member.

Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When You are covered by two or more Plans, the rules for determining the order of benefit payments are:

The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

1. Except as provided in Paragraph 2. below, a Plan that does not contain a Coordination of Benefits provision that is consistent with this COB provision is always primary unless the provisions of both Plans state that the complying Plan is primary.

2. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage will be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are placed over base plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide Out-of-Network benefits.

A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

Each Plan determines its order of benefits using the first of the following rules that apply:

Rule 1 - Non-Dependent or Dependent. The Plan that covers You other than as a Dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan, and the Plan that covers You as a Dependent is the Secondary Plan. However, if You are a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering You as a Dependent and primary to the Plan covering You as other than a Dependent (e.g., a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering You as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan covering You as a Dependent is the Primary Plan.

Rule 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:

1. For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
 - the Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
 - if both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
2. For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
 - 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;
 - 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;
 - 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
 - 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:
 - The Plan covering the Custodial parent;
 - The Plan covering the Spouse of the Custodial parent;
 - The Plan covering the non-custodial parent; and then
 - 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.

Rule 3 - Active Employee or Retired or Laid-off Employee. The Plan that covers You as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan also covering You as a retired or laid-off employee is the Secondary Plan. The same would hold true if You are a Dependent of an active employee and You are a Dependent of a retired or laid-off employee. If the

other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

Rule 4 - COBRA. If You are covered under COBRA or under a right of continuation provided by other federal law and are covered under another Plan, the Plan covering You as an employee, member, subscriber or retiree or covering You as a Dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits. This rule does not apply when the person is covered either: (a) as a non- Dependent under both Plans (i.e. the person is covered under a right of continuation as a qualified beneficiary who, on the day before a qualifying event, was covered under the group health plan as an employee or as a retired employee and is covered under his or her own Plan as an employee, member, subscriber or retiree); or (b) as a Dependent under both plans (i.e. the person is covered under a right of continuation as a qualified beneficiary who, on the day before a qualifying event, was covered under the group health plan as a Dependent of an employee, member or subscriber or retired employee and is covered under the other plan as a Dependent of an employee, member, subscriber or retiree).

Rule 5 - Longer or Shorter Length of Coverage. The Plan that covered You longer is the Primary Plan and the Plan that covered You the shorter period of time is the Secondary Plan.

Rule 6 - If the preceding rules do not determine the order of benefits, the Allowable expenses will be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

EFFECT ON THE BENEFITS OF THIS PLAN

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, we start with this Plan's Allowable expense, deduct the Primary Plan's payment and then deduct any Deductibles, Coinsurance or Copayments.

If You are enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one Closed panel plan, COB will not apply between that Plan and other Closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. Anthem may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. Anthem need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Anthem any facts Anthem needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, This Plan may pay that amount to the organization that 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 payments made by This Plan is more than should have paid under this COB provision, the Plan may recover the excess from one or more of the persons:

1. the Plan has paid or for whom the Plan have paid; or
2. any other person or organization that may be responsible for the benefits or services provided for the Member.

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

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

To the extent permitted by law, this Plan will pay Benefits second to Medicare when You become eligible for Medicare, even if You don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- Subscribers with active current employment status age 65 or older and their Spouses age 65 or older, and
- individuals with end-stage renal disease, for a limited period of time.

Determining the Allowable Expense When This Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the Allowable Expense, as long as the Provider accepts Medicare. If the Provider does not accept Medicare, the Medicare limiting charge (the most a Provider can charge You if they don't accept Medicare) will be the Allowable Expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the total Allowable Expense.

If You are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, Benefits payable under this Plan will be reduced by the amount that would have been paid if You had been enrolled in Medicare.

SUBROGATION AND REIMBURSEMENT

These 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.

Recovery

A "Recovery" includes, but is not limited to, monies received from any person or party, any person's or party's liability insurance, uninsured/underinsured motorist proceeds, workers' compensation insurance or fund, "no-fault" insurance and/or automobile medical payments coverage, whether by lawsuit, settlement or otherwise. Regardless of how You or Your representative or any agreements characterize the money You receive as a Recovery, it shall be subject to these provisions.

Subrogation

The Plan has the right to recover payments it makes on Your behalf from any party responsible for compensating You for Your illnesses or injuries. The following apply:

- The Plan has first priority from any Recovery for the full amount of benefits it has paid regardless of whether You are fully compensated, and regardless of whether the payments You receive make You whole for Your losses, illnesses and/or injuries.
- You and Your legal representative must do whatever is necessary to enable the Plan to exercise the Plan's rights and do nothing to prejudice those rights.
- In the event that You or Your legal representative fail to do whatever is necessary to enable the Plan to exercise its subrogation rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.
- 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.
- 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 without the Plan's prior written consent. 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.

Reimbursement

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 and the following provisions will apply:

- You must 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.
- Notwithstanding any allocation or designation of Your Recovery (e.g., pain and suffering) made in a settlement agreement or court order, the Plan shall have a right of full recovery, in first priority, against any Recovery. Further, the Plan's rights will not be reduced due to Your negligence.
- You and Your legal representative must hold in trust for the Plan the proceeds of the gross Recovery (*i.e.*, the total amount of Your Recovery before attorney fees, other expenses or costs) to be paid to the Plan immediately upon Your receipt of the Recovery. You must reimburse the Plan, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. 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.
- 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 that 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 portions 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.
 - The Plan is entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate You or make You whole.

Your Duties

- You must notify the Plan promptly of how, when and where an accident or incident resulting in personal Injury or illness to You occurred and all information regarding the parties involved.
- 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 fail 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 must not do anything to prejudice the Plan's rights.
- 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.

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

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 this provision. Likewise, if the covered person's relatives, heirs, and/or assignees make any Recovery because of injuries sustained by the covered person, that Recovery shall be subject to this provision.

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.

The Plan is entitled to recover its attorney's fees and costs incurred in enforcing this provision.

GENERAL INFORMATION

Entire Agreement

This Benefit Booklet, the Administrative Services Agreement, the Employer's application, any Riders, Endorsements or attachments, and the individual applications of the Planholders and Members, if any, constitute the entire agreement between Anthem and the Employer and as of the Effective Date, supersede all other agreements between the parties. Any and all statements made to Anthem by the Employer, and any and all statements made to the Employer by Anthem, are representations and not warranties, and no such statement unless it is contained in a written application for coverage under the Plan, shall be used in defense to a claim under the Plan.

Form or Content of Benefit Booklet

No agent or employee of Anthem is authorized to change the form or content of this Benefit Booklet. Such changes can be made only through an endorsement authorized and signed by an officer of the Employer.

Circumstances Beyond the Control of the Plan

Anthem shall make a good-faith effort to arrange for an alternative method of administering benefits. In the event of circumstances not within the control of Anthem or Employer, including but not limited to: a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, labor disputes not within the control of Anthem, disability of a significant part of a Network Provider's personnel or similar causes, or the rendering of health care services provided by the Plan is delayed or rendered impractical Anthem shall make a good-faith effort to arrange for an alternative method of administering benefits. In such event, Anthem and Network Providers shall administer and render services under the Plan insofar as practical, and according to their best judgment; but Anthem and Network Providers shall incur no liability or obligation for delay, or failure to administer or arrange for services if such failure or delay is caused by such an event.

Protected Health Information Under HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Privacy Regulations issued under HIPAA, contain provisions designed to protect the privacy of certain individually identifiable health information. Your Employer's Group Health Plan has a responsibility under the HIPAA Privacy Regulations to provide You with a Notice of Privacy Practices. This notice sets forth the Employer's rules regarding the disclosure of Your information and details about a number of individual rights You have under the Privacy Regulations. The Kentucky Employees' Health Plan Notice of Privacy Practices can be viewed at kehp.ky.gov or You may request a hard copy by calling KEHP at 888-581-8834. As the Claims Administrator of Your Employer's Plan, Anthem has also adopted a number of privacy practices and has described those in its Privacy Notice. If You would like a copy of Anthem's Notice, contact the customer service number on Your Identification Card.

Workers' Compensation

The benefits under the Plan are not designed to duplicate any benefit for which Members are eligible under the Workers' Compensation Law. All sums paid or payable by Workers' Compensation for services provided to a Member shall be reimbursed by, or on behalf of, the Member to the Plan to the extent the Plan has made or makes payment for such services. It is understood that coverage hereunder is not in lieu of, and shall not affect, any requirements for coverage under Workers' Compensation or equivalent employer liability or indemnification law.

Other Government Programs

Except insofar as applicable law would require the Plan to be the primary payer, the benefits under the Plan shall not duplicate any benefits to which Members are entitled, or for which they are eligible under

any other governmental program. To the extent the Plan has duplicated such benefits, all sums payable under such programs for services to Members shall be paid by or on behalf of the Member to the Plan.

Medicare Program

When You are eligible for the Medicare program and Medicare is allowed by federal law to be the primary payer, the benefits described in this Benefit Description will be reduced by the amount of benefits allowed under Medicare for the same *Covered Services*. This reduction will be made whether or not You actually receive the benefits from Medicare. For the purposes of the calculation of benefits, if the Member has not enrolled in Medicare Part B, the Plan will calculate benefits as if they had enrolled.

- **If You Are Under Age 65 With End Stage Renal Disease (ESRD)**
If You are under age 65 and eligible for Medicare only because of ESRD (permanent kidney failure), the Plan will provide the benefits described in this Benefit Description before Medicare benefits. This includes the Medicare “three month waiting period” and the additional **30 months** after the Medicare effective date. After 33 months, the benefits described in this Benefit Description will be reduced by the amount that Medicare allows for the same *Covered Services*.
- **If You Are Under Age 65 With Other Disability**
If You are under age 65 and eligible for Medicare only because of a disability other than ESRD, the Plan will provide the benefits described in this Benefit Description before Medicare benefits. This is the case **only** if You are the actively employed Planholder or the enrolled Spouse or child of the actively employed Planholder.
- **If You Are Age 65 or Older**
If You are age 65 or older and eligible for Medicare only because of age, the Plan will provide the benefits described in this Benefit Description before Medicare. This can be the case **only** if You are an actively employed Planholder or the enrolled Spouse of the actively employed Planholder.

Right of Recovery

Whenever payment has been made in error, the Plan will have the right to recover such payment from You or, if applicable, the Provider. In the event the Plan recovers a payment made in error from the Provider, except in cases of fraud, the Plan will only recover such payment from the Provider during the 24 months after the date the Plan made the payment on a claim submitted by the Provider. The Plan reserves the right to deduct or offset any amounts paid in error from any pending or future claim. The cost share amount shown in Your Explanation of Benefits is the final determination and You will not receive notice of an adjusted cost share amount as a result of such recovery activity.

Anthem has oversight responsibility for compliance with Provider and vendor and Subcontractor contracts. Anthem may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider, Vendor, or Subcontractor resulting from these audits if the return of the overpayment is not feasible. Anthem has established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise recovery amounts. Anthem will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. Anthem may not provide You with notice of overpayments made by the Plan or You if the recovery method makes providing such notice administratively burdensome.

Relationship of Parties (Claims Administrator - Network Providers)

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

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

Anthem Note

KEHP, on behalf of itself and its Members, hereby expressly acknowledges its understanding that the Administrative Services Agreement (which includes this Benefit Booklet) constitutes a contract solely between KEHP and Anthem and that Anthem is an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the State of Kentucky. The Blue Cross and 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, Anthem is 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. This paragraph shall not create any additional obligations whatsoever on the part of Anthem other than those obligations created under other provisions of the Administrative Services Agreement or this Benefit Booklet.

Notice

Any notice given under the Plan shall be in writing. The notices shall be sent to: KEHP at its principal place of business; to You at the Planholder's address as it appears on the records or in care of KEHP.

Modifications or Changes in Coverage

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 Anthem and KEHP 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.

Fraud

Fraudulent statements on Plan enrollment forms or on electronic submissions will invalidate any payment or claims for services and be grounds for voiding the Member's coverage.

Acts Beyond Reasonable Control (Force Majeure)

Should the performance of any act required by this coverage be prevented or delayed by reason of any act of God, strike, lock-out, labor troubles, restrictive government laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event, however, all parties shall use reasonable efforts to perform their respective obligations.

Anthem will adhere to the Plan Sponsor's instructions and allow the Plan Sponsor to meet all of the Plan Sponsor's responsibilities under applicable state and federal law. It is the Plan Sponsor's responsibility to adhere to all applicable state and federal laws and Anthem does not assume any responsibility for compliance.

Conformity with Law

Any provision of the Plan which is in conflict with the applicable federal laws and regulations is hereby amended to conform with the minimum requirements of such laws.

Clerical Error

Clerical error, whether of Anthem or KEHP, in keeping any record pertaining to this coverage will not invalidate coverage otherwise validly in force or continue benefits otherwise validly terminated.

Policies and Procedures

Anthem, on behalf of KEHP, may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of the Plan with which a Member shall comply.

Under the terms of the Administrative Service Agreement with KEHP, Anthem has the authority, in its discretion, to institute from time to time, utilization management, care management, disease management or wellness pilot initiatives in certain designated geographic areas. These pilot initiatives are part of Anthem's ongoing effort to find innovative ways to make available high quality and more affordable healthcare. A pilot initiative may affect some, but not all Members under the Plan. These programs will not result in the payment of benefits which are not provided in KEHP, unless otherwise agreed to by the KEHP.

Value-Added Programs

Anthem may offer health or fitness related programs to Members, through which You 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 the Plan but are in addition to plan benefits. As such, program features are not guaranteed under KEHP and could be discontinued at any time. Anthem does not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services You receive.

Waiver

No agent or other person, except an authorized officer of KEHP, has authority to waive any conditions or restrictions of the Plan, to extend the 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.

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 Anthem, 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

Anthem shall have all the powers necessary or appropriate to enable it to carry out its 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. Anthem has complete discretion to interpret the Benefit Booklet. Anthem's determination shall be final and conclusive and 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.

Governmental Health Care Programs

Under federal law, for groups with 20 or more Employees, all active Employees (regardless of age) can remain on the Group's Health Plan and receive group benefits as primary coverage. Also, Spouses (regardless of age) of active Employees can remain on the Group's Health Plan and receive group benefits as primary coverage. Direct any questions about Medicare eligibility and enrollment to Your local Social Security Administration office.

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.

Payment Innovation Programs

Anthem pays 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 Anthem from time to time, but they will be generally designed to tie a certain portion of a Network Provider's total compensation to pre-defined quality, cost, efficiency or service standards or metrics. In some instances, Network Providers may be required to make payment to Anthem 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 Network Provider's achievement of these pre-defined standards. You are not responsible for any Copayment or Coinsurance amounts related to payments made by or to Anthem under the Program(s), and You do not share in any payments made by Network Providers to Anthem under the Program(s).

Continuation of Coverage (Federal Law-COBRA)

If Your coverage ends under the Plan, You may be entitled to elect continuation coverage in accordance with federal law. If Your employer normally employs 20 or more people, and Your employment is terminated for any reason other than gross misconduct You may elect from 18-36 months of continuation benefits. You should contact Your Employer if You have any questions about Your COBRA rights.

Qualifying events for Continuation Coverage under Federal Law (COBRA)

COBRA continuation coverage is available when Your group 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 covered on the day before the qualifying event and group 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 to elect continuation independently. Each qualified beneficiary has the right to make independent benefit elections at the time of annual enrollment. Covered Planholders 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 Planholder during the period of continuation coverage is also eligible for election of continuation coverage.

Qualifying Event	Length of Availability of Coverage
<p><u>For Employees:</u> 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 Spouses/ Dependents:</u> A Covered Employee'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 Employee's Entitlement to Medicare</p> <p>Divorce or Legal Separation or annulment</p> <p>Death of a Covered Employee</p>	<p>18 months</p> <p>36 months</p> <p>36 months</p> <p>36 months</p>
<p><u>For Dependents:</u> Loss of Dependent Child Status</p>	36 months

Continuation coverage stops before the end of the maximum continuation period if the Member becomes entitled to Medicare benefits. If a continuing beneficiary becomes entitled to Medicare benefits, then 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.)

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 Spouse and Dependent children 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 Spouse or Dependent children to lose coverage under the Plan had the first qualifying event not occurred. A qualified beneficiary must give timely notice to the Plan Administrator in such a situation.

Notification Requirements

In the event of Your termination, lay-off, reduction in work hours or Medicare entitlement, Your Employer must notify the company's benefit Plan Administrator within 30 days. You must notify the company's benefit Plan Administrator within 60 days of Your divorce, legal separation or the failure of Your enrolled Dependents to meet the program's definition of Dependent. This notice must be provided in writing to the Plan Administrator. Thereafter, the Plan Administrator will notify qualified beneficiaries of their rights within 14 days.

To continue enrollment, 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 Premium appropriate for the type of benefit coverage You choose to continue. If the Premium rate changes for active associates, Your monthly Premium will also change. The Premium You must pay cannot be more than

102% of the Premium 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 Premium payment must be made before 45 days after the initial election for continuation coverage, or Your continuation rights will be forfeited.

For Employees 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 Employees who become disabled during the first 60 days of COBRA continuation coverage, coverage may continue from 18 to 29 months. These Employees' Dependents are also eligible for the 18 to 29-month disability extension. (This provision also applies if any covered family member is found to be disabled.) This provision would only apply if the qualified beneficiary provides notice of disability status within 60 days of the disabling determination. In these cases, the Employer can charge 150% of Premium 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. You may also be eligible to receive a tax credit equal to 72.5% of the cost for health coverage for You and Your Dependents charged by the Plan. This tax credit also may be paid in advance directly to the health coverage provider, reducing the amount You have to pay out of pocket.

When COBRA Coverage Ends

These 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 Premium on time;
- a covered individual becomes covered under any other group health plan after electing COBRA;
- a covered individual becomes entitled to Medicare after electing COBRA; or
- the Group 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 Group'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 During Military Leave (USERRA)

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Member may have a right to continuation of benefits subject to the conditions described below.

Under USERRA, if the Employee (or his or her Dependents) is covered under this Plan, and if the Employee becomes absent from employment by reason of military leave, the Employee (or his or her Dependents) may have the right to elect to continue health coverage under the plan. In order to be eligible for coverage during the period that the Employee is gone on military leave, the Employee must give reasonable notice to the Employer of his or her military leave and the Employee will be entitled to COBRA-like rights with respect to his or her medical benefits in that the Employee and his or her Dependents can elect to continue coverage under the plan for a period of 24 months from the date the military leave commences or, if sooner, the period ending on the day after the deadline for the Employee to apply for or return to work with the Employer. During military leave the Employee is required to pay the Employer for the entire cost of such coverage, including any elected Dependents' coverage. However, if the Employee's absence is less than 31 days, the employer must continue to pay its portion of the Premiums and the Employee is only required to pay his or her share of the Premiums without the COBRA-type 2% administrative surcharge.

Also, when the Employee returns to work, if the Employee meets the requirements specified below, USERRA states that the Employer must waive any exclusions and waiting periods, even if the Employee did not elect COBRA continuation. These requirements are (i) the Employee gave reasonable notice to his or her Employer of military leave, (ii) the military leave cannot exceed a prescribed period (which is generally five (5) years, except in unusual or extraordinary circumstances) and the Employee must have received no less than an honorable discharge (or, in the case of an officer, not been sentenced to a correctional institution), and (iii) the Employee must apply for reemployment or return to work in a timely manner upon expiration of the military leave (ranging from a single day up to 90 days, depending upon the period that he or she was gone). The Employee may also have to provide documentation to the Employer upon reemployment that would confirm eligibility. This protection applies to the Employee upon reemployment, as well as to any Dependent who has become covered under the Plan by reason of the Employee's reinstatement of coverage.

Continuation of Coverage Due to Family and Medical Leave (FMLA)

An employee may continue membership in the Plan as provided by the Family and Medical Leave Act. An employee who has been employed at least one year, within the previous 12 months is eligible to choose to continue coverage for up to 12 weeks of unpaid leave for the following reasons:

- The birth of the employee's child.
- The placement of a child with the employee for the purpose of adoption or foster care.
- To care for a seriously ill Spouse, child or parent.
- A serious health condition rendering the employee unable to perform his or her job.

If the employee chooses to continue coverage during the leave, the employee will be given the same health care benefits that would have been provided if the employee were working, with the same premium contribution ratio. If the employee's premium for continued membership in the Plan is more than 30 days late, the Employer will send written notice to the employee. It will tell the employee that his or her membership will be terminated and what the date of the termination will be if payment is not received by that date. This notice will be mailed at least 15 days before the termination date.

If membership in the Plan is discontinued for non-payment of premium, the employee's coverage will be restored to the same level of benefits as those the employee would have had if the leave had not been taken and the premium payment(s) had not been missed. This includes coverage for eligible dependents. The employee will not be required to meet any qualification requirements imposed by the Plan when he or she returns to work. This includes: new or additional waiting periods; waiting for an open enrollment period; or passing a medical exam to reinstate coverage.

Please contact Your Human Resources Department for state specific Family and Medical Leave Act information.

For More Information

This notice does not fully describe the continuation coverage or other rights under the Plan. More information about continuation coverage and Your rights under this Plan is available from the Plan Administrator.

If You have any questions concerning the information in this notice or Your rights to coverage, You should contact Your 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 U.S Department of Labor's Employee Benefits Security Administration (EBSA) in Your area, or visit the EBSA website at www.dol.gov/ebsa.

DEFINITIONS

Accidental Injury

Bodily Injury sustained by a Member as the result of an unforeseen event and which is the direct cause (independent of disease, bodily infirmity or any other cause) for care which the Member receives. Such care must occur while this Plan is in force. It does not include injuries for which benefits are provided under any Workers' Compensation, Employer's liability or similar law.

Administrative Services Agreement

The agreement between Anthem and KEHP regarding the administration of certain elements of the health care benefits of KEHP. This Benefit Booklet in conjunction with the Administrative Services Agreement, the application, if any, any amendment or rider, Your Identification Card and Your application for enrollment constitutes the entire Plan. If there is any conflict between either this Benefit Booklet or the Administrative Services Agreement and any amendment or rider, the amendment or rider shall control. If there is any conflict between this Benefit Booklet and the Administrative Services Agreement, the Administrative Services Agreement shall control.

Ambulance Services

A state-licensed emergency vehicle which carries injured or sick persons to a Hospital. Services which offer non-emergency, convalescent or invalid care do not meet this definition.

Authorized Service(s)

A Covered Service rendered by any Provider other than a Network Provider, which has been authorized in advance (except for Emergency Care which may be authorized after the service is rendered) by Anthem to be paid at the Network level. The Member **may** be responsible for the difference between the Out-of-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Network Coinsurance, Copayment or Deductible. For more information, see the "Claims Payment" section.

Behavioral Health Care

Includes services for Mental Health and Substance Abuse. Mental Health and Substance Abuse is 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 abuse condition.

Benefit Period

One year, January 1 – December 31 (also called year or the calendar year). It does not begin before a Member's Effective Date. It does not continue after a Member's coverage ends.

Centers of Excellence (COE) Network

A network of health care facilities selected for specific services based on criteria such as experience, outcomes, efficiency, and effectiveness. For example, an organ transplant managed care program wherein Members access select types of benefits through a specific network of medical centers.

A network of health care professionals contracted with Anthem or one or more of its affiliates, to provide transplant or other designated specialty services.

Claims Administrator

The company the Plan Sponsor chose to administer its health benefits. Anthem was chosen to administer this Plan. Anthem provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Coinsurance

If a Member's coverage is limited to a certain percentage, for example 70%, then the remaining 30% for which the Member is responsible is the Coinsurance amount. The Coinsurance may be capped by the Out-of-Pocket Maximum.

Combined Limit

The maximum total of In-Network and Out-of-Network benefits available for designated health services in the **Schedule of Benefits**.

Complications of Pregnancy

Complications of Pregnancy result from conditions requiring Hospital confinement when the pregnancy is not terminated. The diagnoses of the complications are distinct from pregnancy but adversely affected or caused by pregnancy.

Such conditions include acute nephritis, nephrosis, cardiac decompensation, missed or threatened abortion, preeclampsia, intrauterine fetal growth retardation and similar medical and surgical conditions of comparable severity. An ectopic pregnancy which is terminated is also considered a Complication of Pregnancy.

Complications of Pregnancy shall not include false labor, caesarean section, occasional spotting, Physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum and similar conditions associated with the management of a difficult pregnancy which are not diagnosed distinctly as Complications of Pregnancy.

Congenital Anomaly

A condition or conditions that are present at birth regardless of causation. Such conditions may be hereditary or due to some influence during gestation.

Coordination of Benefits

A provision that is intended to avoid claims payment delays and duplication of benefits when a person is covered by two or more plans providing benefits or services for medical, dental or other care or treatment. It avoids claims payment delays by establishing an order in which plans pay their claims and providing an authority for the orderly transfer of information needed to pay claims promptly. It may avoid duplication of benefits by permitting a reduction of the benefits of a plan when, by the rules established by this provision, it does not have to pay its benefits first.

Copayment

A cost-sharing arrangement in which a Member pays a specified charge for a Covered Service, such as the Copayment indicated in the **Schedule of Benefits** for an office visit. The Member is usually responsible for payment of the Copayment at the time the health care is rendered. Copayments are distinguished from Coinsurance as flat dollar amounts rather than percentages of the charges for services rendered and are typically collected by the provider when services are rendered.

Cosmetic Surgery

Any non-Medically Necessary surgery or procedure, the primary purpose of which is to improve or change the appearance of any portion of the body, but which does not restore bodily function, correct a disease state, physical appearance or disfigurement caused by an accident, birth defect, or correct or naturally improve a physiological function. Cosmetic Surgery includes but is not limited to rhinoplasty, lipectomy, surgery for sagging or extra skin, any augmentation or reduction procedures (e.g., mammoplasty, liposuction, keloids, rhinoplasty and associated surgery) or treatment relating to the consequences or as a result of Cosmetic Surgery.

Covered Dependent

Any Dependent in a Planholder's family who meets all the requirements of the Eligibility section of this Benefit Booklet, has enrolled in the Plan, and is subject to Administrative Service Fee requirements set forth by the Plan.

Covered Services

Medically Necessary health care services and supplies that are: (a) defined as Covered Services in the Member's Plan, (b) not excluded under such Plan, (c) not Experimental/Investigative and (d) provided in accordance with such Plan.

Covered Transplant Procedure

Any Medically Necessary human organ and stem cell/bone marrow transplants and transfusions as determined by Anthem including necessary acquisition procedures, collection and storage, and including Medically Necessary preparatory myeloablative therapy.

Custodial Care

Any type of care, including room and board, that (a) does not require the skills of professional or technical personnel; (b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of post-Hospital Skilled Nursing Facility care; (c) is a level such that the Member has reached the maximum level of physical or mental function and is not likely to make further significant improvement. Custodial Care includes, but is not limited to, any type of care the primary purpose of which is to attend to the Member's activities of daily living which do not entail or require the continuing attention of trained medical or paramedical personnel. Examples of Custodial Care include, but are not limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of non-infected, post-operative or chronic conditions, preparation of special diets, supervision of medication that can be self-administered by the Member, general maintenance care of colostomy or ileostomy, routine services to maintain other services which, in the sole determination of the Plan, can be safely and adequately self-administered or performed by the average non-medical person without the direct supervision of trained medical and paramedical personnel, regardless of who actually provides the service, residential care and adult day care, protective and supportive care including educational services, rest care and convalescent care.

Deductible

The portion of the bill You must pay before Your medical expenses become Covered Services.

Dependent

The Spouse and all children until attaining age limit stated in the Eligibility section. Children include natural children, legally adopted children, foster children and for whom the Employee is the primary source of financial support, and stepchildren. Also included are Your children (or children of Your Spouse) for whom You have legal responsibility resulting from a valid court decree. Children who are totally and permanently disabled remain covered no matter what age. You must give Anthem evidence of Your child's incapacity within 31 days of attainment of age 26. The certification form may be obtained from Anthem or Your Employer. This proof of incapacity may be required annually by the Plan. A dependent child who is not already covered under the Plan at the time of his/her 26th birthday may not later be enrolled in the Plan on grounds of total and permanent disability unless and until he/she sustains a loss of other insurance coverage.

Detoxification

The process whereby an alcohol or drug intoxicated or alcohol or drug dependent person is assisted, in a facility licensed by the appropriate regulatory authority, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a licensed Physician, while keeping the physiological risk to the patient to a minimum.

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.

Durable Medical Equipment

Equipment which is (a) made to withstand prolonged use; (b) made for and mainly used in the treatment of a disease or Injury; (c) suited for use while not confined as an Inpatient at a Hospital; (d) not normally of use to persons who do not have a disease or Injury; (e) not for exercise or training.

Effective Date

The date for which the Plan approves an individual application for coverage. For individuals who join this Plan after the first enrollment period, the Effective Date is the date KEHP approves each future Member according to its normal procedures.

Elective Surgical Procedure

A surgical procedure that is not considered to be an emergency, and may be delayed by the Member to a later point in time.

Emergency Medical Condition

("Emergency services," "emergency care," or "Medical Emergency") Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Employee

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

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.

Experimental/Investigative

Any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which Anthem determines to be unproven.

Anthem will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if Anthem determines that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply:

- 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;
- Has been determined by the FDA to be contraindicated for the specific use; or
- Is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or

- Is provided pursuant to informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by Anthem. In determining whether a Service is Experimental/Investigative, Anthem will consider the information described below and assess whether:

- The scientific evidence is conclusory 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 investigatory settings.

The information considered or evaluated by Anthem to determine whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative 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, 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 Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- Medical records; or
- The opinions of consulting Providers and other experts in the field.

Anthem has the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative.

Freestanding Ambulatory Facility

A facility, with a staff of Physicians, at which surgical procedures are performed on an Outpatient basis-no patients stay overnight. The facility offers continuous service by both Physicians and registered nurses (R.N.s). It must be licensed and accredited by the appropriate agency. A Physician's office does not qualify as a Freestanding Ambulatory Facility.

Group Health Plan or Plan

The Kentucky Employees' Health Plan, an employer sponsored, self-funded group health insurance plan.

Home Health Care

Care, by a licensed program or provider, for the treatment of a patient in the patient's home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the patient's attending Physician.

Home Health Care Agency

A provider who renders care through a program for the treatment of a patient in the patient's home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the patient's attending Physician. It must be licensed and accredited by the appropriate agency.

Hospice

A provider which provides care for terminally ill patients and their families, either directly or on a consulting basis with the patient's Physician. It must be licensed and accredited by the appropriate agency.

Hospice Care Program

A coordinated, interdisciplinary program designed to meet the special physical, psychological, spiritual and social needs of the terminally ill Member and his or her covered family members, by providing palliative and supportive medical, nursing and other services through at-home or Inpatient care. The Hospice must be licensed and accredited by the appropriate agency and must be funded as a Hospice as defined by those laws. It must provide a program of treatment for at least two unrelated individuals who have been medically diagnosed as having no reasonable prospect of cure for their illnesses.

Hospital

An institution licensed and accredited by the appropriate agency, which is primarily engaged in providing diagnostic and therapeutic facilities on an Inpatient basis for the surgical and medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of Physicians duly licensed to practice medicine, and which continuously provides 24-hour-a-day nursing services by registered graduate nurses physically present and on duty. "Hospital" does not mean other than incidentally:

- an extended care facility; nursing home; place for rest; facility for care of the aged;
- a custodial or domiciliary institution which has as its primary purpose the furnishing of food, shelter, training or non-medical personal services; or
- an institution for exceptional or disabled children.

Identification Card

The latest card given to You showing Your identification and group numbers, the type of coverage You have and the date coverage became effective.

Ineligible Charges

Charges for health care services that are not Covered Services because the services are not Medically Necessary or Precertification was not obtained. Such charges are not eligible for payment.

Ineligible Provider

A provider which does not meet the minimum requirements to become a contracted Provider with Anthem. Services rendered to a Member by such a provider are not eligible for payment.

Infertile or Infertility

The condition of a presumably healthy Member who is unable to conceive or produce conception after a period of one year of frequent, unprotected heterosexual vaginal intercourse. This does not include conditions for men when the cause is a vasectomy or orchiectomy or for women when the cause is tubal ligation or hysterectomy.

Initial Enrollee

A person actively employed by the Employer (or one of that person's Covered Dependents) who was either previously enrolled under the group coverage which this Plan replaces or who is eligible to enroll on the Effective Date of this Plan.

Injury

Bodily harm from a non-occupational accident.

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 Care Unit

A special unit of a Hospital that: (1) treats patients with serious illnesses or Injuries; (2) can provide special life-saving methods and equipment; (3) admits patients without regard to prognosis; and (4) provides constant observation of patients by a specially trained nursing staff.

Late Enrollees

Late Enrollees mean Employees or Dependents who request enrollment in a health benefit plan after the initial open enrollment period. An individual will not be considered a Late Enrollee if: (a) the person enrolls during his/her initial enrollment period under the Plan; (b) the person enrolls during a special enrollment period; or (c) a court orders that coverage be provided for a minor Covered Dependent under a Member's Plan, but only as long as the Member requests enrollment for such Dependent within thirty-one (31) days after the court order is so issued. Late Enrollees are those who declined coverage during the initial open enrollment period and did not submit a certification to the Plan that coverage was declined because other coverage existed.

Maternity Care

Obstetrical care received both before and after the delivery of a child or children. It also includes care for miscarriage or abortion. It includes regular nursery care for a newborn infant as long as the mother's Hospital stay is a covered benefit and the newborn infant is an eligible Member under the Plan.

Maximum Allowed Amount

The maximum amount that the Plan will allow for Covered Services You receive. For more information, see the "Claims Payment" section.

Medical Facility

A facility, including but not limited to, a Hospital, Freestanding Ambulatory Facility, Chemical Dependency Treatment Facility, Skilled Nursing Facility, Home Health Care Agency or mental health facility, as defined in this Benefit booklet. The facility must be licensed, accredited, registered or approved by the Joint Commission on Accreditation of Hospitals or meet specific requirements established by Anthem.

Medical Necessity or Medically Necessary

An intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury and that is determined by Anthem 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. 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: (1) not more costly than an alternative service or sequence of services that is medically appropriate, or (2) the service is performed in the least costly setting that is medically appropriate;
- Not Experimental/Investigative;
- Not primarily for the convenience of the Member, the Member's family or the Provider.
- Not otherwise subject to an exclusion under this Benefit Booklet.

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

Individuals, including the Planholder and his/her Dependents, who have satisfied the Plan eligibility requirements of the Employer, applied for coverage, and been enrolled for Plan benefits.

Network Provider

A Physician, health professional, Hospital, Pharmacy, or other individual, organization and/or facility that has entered into a contract, either directly or indirectly, with Anthem to provide Covered Services to Members through negotiated reimbursement arrangements.

New Hire

A person who is not employed by the Employer on the original Effective Date of the Plan.

Non-Covered Services

Services that are not benefits specifically provided under the Plan, are excluded by the Plan, are provided by an Ineligible Provider, or are otherwise not eligible to be Covered Services, whether or not they are Medically Necessary.

Out-of-Network Provider

A Provider, including but not limited to, a Hospital, Freestanding Ambulatory Facility (Surgical Center), Physician, Skilled Nursing Facility, Hospice, Home Health Care Agency, other medical practitioner or provider of medical services or supplies, that does not have an agreement or contract with Anthem to provide services to its Members at the time services are rendered.

Benefit payments and other provisions of this Plan are limited when a Member uses the services of Out-of-Network Providers.

Out-of-Pocket Maximum

The maximum amount of a Member's Coinsurance payments during a given calendar Plan year. When the Out-of-Pocket Maximum is reached, the level of benefits is increased to 100% of the Maximum Allowed Amount for Covered Services.

Physical Therapy

The care of disease or Injury by such methods as massage, hydrotherapy, heat, or similar care.

Physician

Any licensed Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery, any licensed Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O., any licensed Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and any licensed Doctor of Dental Surgery (D.D.S.) legally entitled to perform oral surgery; Optometrists and Clinical Psychologists (PhD)

are also Providers when acting within the scope of their licenses, and when rendering services covered under this Plan.

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 the Commonwealth of Kentucky. **The Plan Administrator is not Anthem.**

Plan Sponsor

The legal entity that has adopted the Plan and has authority regarding its operation, amendment and termination. The Plan Sponsor is the Commonwealth of Kentucky, Personnel of Cabinet, Department of Employee Insurance. **The Plan Sponsor is not Anthem.**

Primary Care Physician

A provider who specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other provider as allowed by the Plan. A PCP supervises, coordinates and provides initial care and basic medical services to a Member and is responsible for ongoing patient care.

Prior Authorization

The process applied to certain drugs and/or therapeutic categories to define and/or limit the conditions under which these drugs will be covered. The drugs and criteria for coverage are defined by the Pharmacy and Therapeutics Committee.

Provider

A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves. This includes any Provider rendering services which are required by applicable state law to be covered when rendered by such Provider. Providers that deliver Covered Services are described throughout this Benefit Booklet. If You have a question if a Provider is covered, please call the number on the back of your ID card.

QMCSO, or MCSO – Qualified Medical Child Support Order or Medical Child Support Order

A QMCSO creates or recognizes the right of a child who is recognized under the order as having a right to be enrolled under the health benefit plan to receive benefits for which the Employee is entitled under the plan; and includes the name and last known address of the Employee and each such child, a reasonable description of the type of coverage to be provided by the plan, the period for which coverage must be provided and each plan to which the order applies.

An MCSO is any court judgment, decree or order (including a court's approval of a domestic relations settlement agreement) that:

- provides for child support payment related to health benefits with respect to the child of a group health plan Member or requires health benefit coverage of such child in such plan, and is ordered under state domestic relations law; or
- enforces a state law relating to medical child support payment with respect to a group health plan.

Retail Health Clinic

A facility that provides limited basic medical care services to Members on a “walk-in” basis. These clinics normally operate in major pharmacies or retail stores. Medical services are typically provided by Physicians Assistants and Nurse Practitioners. Services are limited to routine care and treatment of common illnesses for adults and children.

Semi-private Room

A Hospital room which contains two or more beds.

Skilled Convalescent Care

Care required, while recovering from an illness or Injury, which is received in a Skilled Nursing Facility. This care requires a level of care or services less than that in a Hospital, but more than could be given at the patient’s home or in a nursing home not certified as a Skilled Nursing Facility.

Skilled Nursing Facility

An institution operated alone or with a Hospital which gives care after a Member leaves the Hospital for a condition requiring more care than can be rendered at home. It must be licensed by the appropriate agency and accredited by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or otherwise determined by Anthem to meet the reasonable standards applied by any of the aforesaid authorities.

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.

Spouse

For the purpose of this Plan, a Spouse is a person to whom You are legally married.

Transplant Providers

Network Transplant Provider - A Provider that has been designated as a “Center of Excellence” for Transplants by Anthem and/or a Provider selected to participate as a Network Transplant Provider by the Blue Cross and Blue Shield Association. Such Provider has entered into a transplant provider agreement to render Covered Transplant Procedures and certain administrative functions to You for the transplant network. A Provider may be a Network Transplant Provider with respect to:

- certain Covered Transplant Procedures; or
- all Covered Transplant Procedures.

Out-of-Network Transplant Provider - Any Provider that has NOT been designated as a “Center of Excellence” for Transplants by Anthem nor has not been selected to participate as a Network Transplant Provider by the Blue Cross and Blue Shield Association.

Urgent Care

Services received for a sudden, serious, or unexpected illness, Injury or condition. Urgent Care is not considered an emergency. Care is needed right away to relieve pain, find out what is wrong, or treat a health problem that is not life-threatening.

Utilization Review

A function performed by Anthem or by an organization or entity selected by Anthem to review and approve whether the services provided are Medically Necessary, including but not limited to, whether acute hospitalization, length of stay, Outpatient care or diagnostic services are appropriate.

You and Your

Refer to the Planholder, Member and each Covered Dependent.

HEALTH BENEFITS COVERAGE UNDER FEDERAL LAW

Choice of Primary Care Physician

The Plan generally allows the designation of a Primary Care Physician (PCP). You have the right to designate any PCP who participates in Anthem's 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 Anthem's 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 the Plan or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in Anthem's 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 or 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 Anthem's website, www.anthem.com.

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 (e.g., Your Physician, nurse midwife, or Physician assistant), 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). However, to use certain providers or facilities, or to reduce Your out-of-pocket costs, You may be required to obtain Precertification. For information on Precertification, contact Your Plan Administrator.

Also, under federal law, plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48 hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

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;
- Prosthesis; 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.**

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 Your employer or Plan Administrator 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 abuse benefits with day/visit limits on medical/surgical benefits. In general, group health plans offering mental health and substance abuse benefits cannot set day/visit limits on mental health or substance abuse benefits that are lower than any such day/visit limits for medical and surgical benefits. A plan that does not impose day/visit limits on medical and surgical benefits may not impose such day/visit limits on mental health and substance abuse benefits offered under the Plan. Also, the Plan may not impose Deductibles, Copayment/Coinsurance and out of pocket expenses on mental health and substance abuse benefits that are more restrictive than Deductibles, Copayment/Coinsurance and out of pocket expenses applicable to other medical and surgical benefits. 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 Employees and Dependents may also enroll under two additional circumstances:

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

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

GINA

This Plan is compliant with the Genetic Information Non-Discrimination Act of 2008.

PLAN ADMINISTRATION

NOTE: This section is not a part of your Benefit Booklet. Anthem is not responsible for any statements contained herein that are not set forth in the Administrative Services Agreement or the Benefit Booklet.

- **Plan Name: Kentucky Employees' Health Plan**
- **Plan Sponsor: Commonwealth of Kentucky
Personnel Cabinet, Department of Employee Insurance
501 High Street, Second Floor
Frankfort, KY 40601**
- **Employer I.D. Number: 61-0600439**
- **Type of Plan: The Plan is an Employee welfare benefit plan providing group medical benefits.**
- **Plan Year Ends: 12/31**
- **Type of Administration/Funding: Medical benefits are furnished under a health care plan funded by the Plan Sponsor on a self-funded basis with claims being administered by Anthem Insurance Companies, Inc.**
- **Plan Administrator and Named Fiduciary: Commonwealth of Kentucky
501 High Street
Frankfort, KY 40601**
- **Agent for Service of Legal Process: Commonwealth of Kentucky
Deputy Executive Director, Office of Legal Services
501 High Street, Third Floor
Frankfort, KY 40601**

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