Your Individual Health Contract

RIGHT TO EXAMINE THIS CONTRACT: You have ten (10) days to examine this contract. If you are not satisfied with this contract, you may return it to us or the agent who sold it to you within ten (10) days after you receive it or have access to it electronically, whichever is earlier. Your premium will be refunded and this contract will be void from its start.

Guaranteed Renewable: Renewability of coverage under this contract is at the sole option of the Member. The Member may renew this contract by payment of the renewal premium by the end of the grace period of any premium due date. This KYHC Plan may refuse renewal only under certain conditions, as explained in the "*Changes in Coverage: Termination and Reinstatement To*" section.

Kentucky Health Cooperative, INC.
9700 Ormsby Station Rd. Suite 100.
Louisville, KY 40233
Phone: 1-855-OUR-KYHC (687-5942)
TTY: 1-800-648-6056

CONTRACT COVER SHEET

This document is a legal contract between the contract owner (Subscriber) and us.

THIS DOCUMENT, TOGETHER WITH YOUR APPLICATION (INCLUDING ANY AFFIDAVITS) AND YOUR I.D. CARD IS YOUR CONTRACT. READ YOUR CONTRACT CAREFULLY.

The *Schedule of Benefits* shows the cost share option you selected. The *Schedule of Benefits* also provides a brief outline of some of the important features of your contract. The *Schedule of Benefits* is not the health contract and only the actual contract provisions will control. The contract itself is a legal contract and sets forth in detail the rights and obligations of both you and this KYHC Plan.

IT IS IMPORTANT THAT YOU READ YOUR CONTRACT.

If you do not want the contract for any reason, you may return it to us within ten (10) days after you receive it. Upon return, the contract will be deemed void, and any money you have paid will be refunded provided no services have been obtained.

FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT NOTICES

Choice of Primary Care Physician

We allow the designation of a Primary Care Physician (PCP). You will have the right to designate any PCP who participates in our Network and who is available to accept members. For information on how to select a PCP, and for a list of PCPs, contact the telephone number on the back of the identification card or refer to our website, www.mykyhc.org. For children, members may designate a pediatrician as the PCP.

Access to Obstetrical and Gynecological (Ob-Gyn) Care

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

INTRODUCTION

Welcome to Kentucky Health Cooperative Inc.! This contract has been prepared by us to help explain your coverage. Please refer to this contract whenever you require medical services. It describes how to access medical care, what health services are covered by us, and what portion of the health care costs you will be required to pay.

This contract, the application, and any amendments or riders attached shall constitute the entire contract under which covered services and supplies are provided by us.

This contract should be read and re-read in its entirety. Since many of the provisions of this contract are interrelated, you should read the entire contract to get a full understanding of your coverage.

Many words used in the contract have special meanings. These words may be capitalized. If the word or phrase was not explained in the text where it appears, it may be defined in the *Definitions* section. Refer to these definitions for the best understanding of what is being stated

This contract also contains "Non-covered services/Exclusions" so please be sure to read this contract carefully.

If you have any questions about this contract, please call the member service number located on the back of your Identification (ID) Card or visit www.mykyhc.org.

How to Obtain Language Assistance

We are committed to communicating with our Members about their health plan, regardless of their language. We employ 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.

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Chief Executive Officer-Janie Miller

MEMBER RIGHTS AND RESPONSIBILITIES

We are committed to:

- Recognizing and respecting you as a Member.
- Encouraging your open discussions with your health care professionals and Providers.
- Providing information to help you become an informed health care consumer.
- Providing access to health benefits and our Network providers.
- Sharing our expectations of you as a Member.

You have the right to:

- Participate with your health care professionals and providers in making decisions about your health care.
- Receive the benefits for which you have coverage .
- Be treated with respect and dignity and have the right to privacy.
- Privacy of your personal health information, consistent with state and federal laws, and our policies.
- Receive information about our organization and services, our network of health care professionals and providers, and your rights and responsibilities.
- Candidly discuss with your physicians and providers appropriate or Medically Necessary care for your condition, regardless of cost or benefit coverage.
- Make recommendations regarding the organization's Members' rights and responsibilities policies.
- Voice complaints or appeals about: our organization, any benefit or coverage decisions we (or our designated administrators) make, your coverage, or care provided.
- Refuse treatment for any condition, illness or disease without jeopardizing future treatment, and be informed by your physician(s) of the medical consequences.
- Participate in matters of the organization's policy and operations.

You have the responsibility to:

- Choose a participating Primary Care Physician in your health benefit plan.
- Treat all health care professionals and staff with courtesy and respect.
- Keep scheduled appointments with your doctor, and call the doctor's office if you have a delay or cancellation.
- Read and understand to the best of your ability all materials concerning your health benefits or ask for help if you need it.
- Understand your health problems and participate, along with your health care professionals and providers in developing mutually agreed upon treatment goals to the degree possible.
- Supply, to the extent possible, information that we and/or your health care professionals and providers need in order to provide care.
- Follow the plans and instructions for care that you have agreed on with your health care professional and provider.
- Tell your health care professional and provider if you do not understand your treatment plan or what is expected of you.
- Follow all health benefit plan guidelines, provisions, policies and procedures.
- Let our Customer Service Department know if you have any changes to your name, address, or family members covered under your policy.
- Provide us with accurate and complete information needed to administer your health benefit plan, including other health benefit coverage and other insurance benefits you may have in addition to your coverage with us.

We are committed to providing quality benefits and customer service to our Members. Benefits and coverage for services provided under the benefit program are governed by the Contract and not by this Member Rights and Responsibilities statement.

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COVERED SERVICES

This section describes the covered services available under your health care benefits when provided and billed by providers. For most services, care must be received from a Primary Care Physician (PCP), Specialty Care Physician (SCP) or another network provider to be a Covered Service, except for Emergency Care and Urgent Care. Services which are not received from a PCP, SCP or another network provider or approved as an authorized service will be considered a Non-network service, except as specified above. The amount payable for Covered services varies depending on whether you receive your care from a PCP, SCP or another network provider or a non-network provider, except for emergency care and urgent care.

If you use a non-network provider, you are responsible for the difference between the Non-network provider's charge and the Maximum Allowable Amount, in addition to any applicable Coinsurance, Copayment or Deductible. **We cannot prohibit Non-network providers from billing you for the difference in the non-network provider's charge and the Maximum Allowable Amount.**

All covered services and benefits are subject to the conditions, Exclusions, limitations, terms and provisions of this contract, including any attachments, riders and endorsements. Covered services must be Medically Necessary and not Experimental/Investigative. The fact that a provider may prescribe, order, recommend or approve a service, treatment or supply does not make it Medically Necessary or a covered Service and does not guarantee payment. To receive maximum benefits for covered services, you must follow the terms of the contract, including receipt of care from a PCP, SCP or another Network provider, and obtain any required Prior Authorization or Precertification. Contact your Network provider to be sure that Prior Authorization/Precertification has been obtained. We base our decisions about Prior Authorization/Precertification, Medical Necessity, Experimental/Investigative services and new technology on our clinical coverage guidelines and medical policy. We may also consider published peer-review medical literature, opinions of experts and the recommendations of nationally recognized public and private organizations which review the medical effectiveness of health care services and technology. Benefits for covered services may be payable subject to an approved treatment plan created under the terms of this contract. Benefits for covered services are based on the Maximum Allowable Amount for such service. **Our payment for covered services will be limited by any applicable Coinsurance, Copayment, Deductible, or benefit period limit/maximum in this contract.**

Ambulance Services

See the *Schedule of Benefits* for any applicable Deductible, Coinsurance, Copayment, and benefit limitation information.

Ambulance Services are transportation by a vehicle (including ground, water, fixed wing and rotary wing air transportation) designed, equipped and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals:

- • From your home, scene of accident or medical emergency to a hospital;
- • Between hospitals;
- • Between a hospital and skilled nursing facility; or
- • From a hospital or skilled nursing facility to your home.

Treatment of a sickness or injury by medical professionals from an ambulance service when you are not transported will be covered if Medically Necessary. Other vehicles which do not meet this definition, including ambulettes, are not covered services.

Ambulance services are a covered service only when Medically Necessary, except:

- When ordered by an employer, school, fire or public safety official and you are not in a position to refuse; or
- When you are required by us to move from a non-network provider to a Network provider.

Ambulance trips must be made to the closest local facility that can give covered services appropriate for your condition. If none of these facilities are in your local area, you are covered for trips to the closest facility outside your local area. Ambulance usage is not covered when another type of transportation can be used without endangering the Member's health. Any ambulance usage for the convenience of the Member, family or physician is not a covered service. Non-covered services for ambulance include trips to:

- • a physician's office or clinic;
- • a morgue or funeral home.

Autism Spectrum Disorders
See the *Schedule of Benefits* for any applicable Deductible, Coinsurance, Copayment, and Benefit limitation information.

The diagnosis and treatment of Autism Spectrum Disorders for Members ages one (1) through twenty-one (21) is covered. Autism Spectrum Disorders means a physical, mental, or cognitive illness or disorder which includes any of the pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders ("DSM") published by the American Psychiatric Association, including Autistic Disorder, Asperger's Disorder, and Pervasive Developmental Disorder not otherwise specified.

Treatment for autism spectrum disorders includes the following care for an individual diagnosed with any of the autism spectrum disorders:

- Medical care - services provided by a licensed physician, an advanced registered nurse practitioner, or other licensed health care provider;
- Habilitative or rehabilitative care - professional counseling and guidance services, therapy, and treatment programs, including applied behavior analysis, that are necessary to develop, maintain, and restore, to the maximum extent practicable, the functioning of an individual;
- Pharmacy care includes medically necessary medications prescribed by a licensed physician or other health-care practitioner with prescribing authority, if covered by the plan, and any medically necessary health-related services to determine the need or effectiveness of the medications;
- Psychiatric care - direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices;
- Psychological care - direct or consultative services provided by an individual licensed by the Kentucky Board of Examiners of Psychology or by the appropriate licensing agency in the state in which the individual practices;
- Therapeutic care - services provided by licensed speech therapists, occupational therapists, or physical therapists; and

- Applied behavior analysis prescribed or ordered by a licensed health or allied health professional. Applied behavior analysis means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior

No reimbursement is required under this section for services, supplies, or equipment:

- For which the Member has no legal obligation to pay in the absence of this or like coverage;
- Provided to the Member by a publicly funded program;
- Performed by a relative of a Member for which, in the absence of any health benefits coverage, no charge would be made; and
- For services provided by persons who are not licensed as required by law.

Behavioral Health Services
See the *Schedule of Benefits* for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered services include but are not limited to:

Inpatient services **-** individual or group psychotherapy, psychological testing, family counseling with family members to assist in your diagnosis and treatment, convulsive therapy including electroshock treatment or convulsive drug therapy.. If we determine the services you receive are not Medically Necessary under your plan and you received your care from a non-network provider, you will be financially responsible for the services.

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Partial hospitalization **-** an intensive structured setting providing three (3) or more hours of treatment or programming per day or evening, in a program that is available five (5) days a week. The intensity of services is similar to Inpatient settings. Skilled nursing care and daily psychiatric care (and substance abuse care if the patient is being treated in a partial hospital substance abuse program) are available, and treatment is provided by a multidisciplinary team of behavioral health professionals.

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- **Intensive Outpatient treatment or day treatment -** a structured array of treatment services, offered by practice groups or facilities to treat behavioral health conditions. Intensive outpatient programs provide three (3) hours of treatment per day, and the program is available at least 2-3 days per week. Intensive outpatient programs may offer group, DBT, individual, and family services.

- **Outpatient treatment, or individual or group treatment -** office-based services, for example diagnostic evaluation, counseling, psychotherapy, family therapy, and medication evaluation. The service may be provided by a licensed mental health professional and is coordinated with the psychiatrist.

Non-Covered Behavioral Health Services (*please also see the Exclusions section of this contract for other non-Covered services*)

- **Residential Treatment services** - Residential treatment means individualized and intensive treatment in a residential setting, including observation and assessment by a psychiatrist weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities.
- Custodial or domiciliary care.
- Supervised living or halfway houses.
- Room and board charges unless the treatment provided meets our Medical Necessity criteria for in-patient admission for your condition.
- Services or care provided or billed by a school, halfway house, custodial care center for the developmentally disabled or outward bound programs, even if psychotherapy is included.
- Services related to non-compliance of care if you end treatment for substance abuse against the medical advice of the provider.

**Coinsurance, Copayments and limits are specified above, in the *Schedule of Benefits*.

We encourage you to contact our Mental Health/Substance Abuse Subcontractor to verify the use of appropriate procedures, setting and Medical Necessity. When you obtain prior approval from our Mental Health/Substance Abuse Subcontractor and receive services from the provider designated by that approval, covered services will be considered a Network service. If you do not obtain prior approval, covered services will be considered a non-network service.

Cancer Clinical Trials

Benefits are available for services for routine patient care rendered as part of a cancer clinical trial if the services are otherwise covered services under this contract and the clinical trial meets all of the following criteria:

The trial is approved by one of the following:

- The National Institutes of Health, or any institutional review board recognized by the National Institutes of Health;
- The United States Food and Drug Administration;
- The United States Department of Defense; or
- The United States Veterans Administration; and

The trial does one of the following:

- Tests how to administer a health care service, item, or drug for the treatment of cancer;
- Tests responses to a health care service, item, or drug for the treatment of cancer;
- Compares the effectiveness of health care services, items, or drugs for the treatment of cancer; or
- Studies new uses of health care services, items, or drugs for the treatment of cancer.

<u>Benefits do not, however, include the following</u>:

1. The healthcare service, item, or investigational drug that is the subject of the cancer clinical trial;

2. Any treatment modality outside the usual and customary standard of care required to administer or support the healthcare service, item, or investigational drug that is the subject of the cancer clinical trial;
3. Any healthcare service, item, or drug provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient;
4. An investigational drug or device that has not been approved for market by the United States Food and Drug Administration;
5. Transportation, lodging, food, or other expenses for the patient or a family member or companion of the patient that are associated with travel to or from a facility providing the cancer clinical trial;
6. Any services, items, or drugs provided by the cancer clinical trial sponsors free of charge for any new patient; or
7. Any services, items, or drugs that are eligible for reimbursement by a person other than the insurer, including the sponsor of the clinical trial.

Congenital Defects and Birth Abnormalities
Covered services include coverage for necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

Dental Services
See the *Schedule of Benefits* for any applicable Deductible, Coinsurance, Copayment, and benefit limitation information.

Related to Accidental Injury
Outpatient services, physician home visits and office services, emergency care and urgent care services for dental work and oral surgery are covered if they are 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 patient's condition. Injury as a result of chewing or biting is not considered an accidental injury. "Initial" dental work to repair injuries due to an accident means performed within twelve (12) months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

Covered services for accidental dental include, but are not limited to:

- • oral examinations.
- • x-rays.
- • tests and laboratory examinations.
- • restorations.
- • prosthetic services.
- • oral surgery.
- • mandibular/maxillary reconstruction.
- • anesthesia.

NOTE: *General anesthesia is a drug, gas or other modality that, when administered, causes a complete loss of sensation and a loss of consciousness.*

Other Dental Services
Benefits are provided for anesthesia and hospital or facility charges for services performed in a hospital and ambulatory surgical facility. These services must be in connection with dental procedures for dependents below the age of nine (9) years. Members with serious mental or physical conditions and Members with significant behavioral problems. Also, the admitting physician or dentist must certify that, because of the patient's age, condition or problem, hospitalization or general anesthesia is required, in order to safely and effectively perform the procedures. Benefits are not provided for routine dental care. If the above paragraph does not apply to a Member, the only other dental expenses that are Covered services are facility charges for outpatient services for the removal of teeth or for other dental processes. Benefits are payable only if the patient's medical condition or the dental procedure requires a hospital setting to ensure the safety of the patient.

Diabetic Equipment, Education and Supplies
See the *Schedule of Benefits* for any applicable Deductible, Coinsurance, and Benefit limitation information.

Diabetes self-management training for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when:

- Medically Necessary;
- Ordered in writing by a physician or a podiatrist; and
- Provided by a certified, registered, or licensed health care professional with expertise in diabetes, as deemed necessary by a health care provider.

For the purposes of this provision, a "Health Care Professional" means the physician or podiatrist ordering the training or a provider who has obtained certification in diabetes education by the American Diabetes Association. (*See "Medical Supplies, Durable Medical Equipment, and Appliances" "Preventive Care Services", "Physician Home Visits and Office Services", and "Prescription Drug Benefits*")

Covered services also include all physicians prescribed medically necessary equipment, supplies, and all medications necessary for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and noninsulin-using diabetes if prescribed by a health care provider legally authorized to prescribe the items. (*See "Medical Supplies, Durable Medical Equipment, and Appliances" "Preventive Care Services", "Physician Home Visits and Office Services", and "Prescription Drug Benefits*")

DIAGNOSTIC SERVICES

Diagnostic Services
See the *Schedule of Benefits* for any applicable Deductible, Coinsurance, Copayment, and Benefit limitation information.

Diagnostic services are tests or procedures performed when you have specific symptoms, to detect or monitor your condition. Coverage for diagnostic services, including when provided as part of physician home visits and office services, inpatient services, outpatient services, home care services, and hospice services includes but is not limited to:

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease.
- Magnetic Resonance Angiography (MRA).
- Magnetic Resonance Imaging (MRI).
- CAT scans.
- Laboratory and pathology services.
- Cardiographic, encephalographic, and radioisotope tests.
- Nuclear cardiology imaging studies
- Ultrasound services.
- Allergy tests.
- Electrocardiograms (EKG).
- Electromyograms (EMG) except that surface EMG's are not Covered services.
- Echocardiograms.
- Bone density studies.
- Positron emission tomography (PET scanning).
- Diagnostic tests as an evaluation to determine the need for a covered transplant procedure
- Echographies.
- Doppler studies.
- Brainstem evoked potentials (BAER).
- Somatosensory evoked potentials (SSEP)
- Visual evoked potentials (VEP)
- Nerve conduction studies.
- Muscle testing.
- Electrocorticograms.

Central supply (IV tubing) or pharmacy (dye) necessary to perform tests is covered as part of the test, whether performed in a hospital or physician's office. For diagnostic services other than those approved to be received in a physician's office, you may be required to use our independent laboratory Network provider. When diagnostic radiology is performed in a Network physician's office, no Copayment is required. Any Coinsurance from a Network or a non-network physician will still apply.

Emergency Care and Urgent Care Services
See the *Schedule of Benefits* for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Emergency Care (including Emergency Room Services)

If you are experiencing an Emergency, call 9-1-1 or go to the nearest hospital. Services which we determine to meet the definition of emergency care will be covered, whether the care is rendered by a Network provider or non-network provider. Emergency care rendered by a non-network provider will be covered as a Network service; however you may be responsible for the difference between the non-network provider's charge and the Maximum Allowable Amount, in addition to any applicable Coinsurance, Copayment or Deductible. If you contact your physician and are referred to a hospital emergency room, benefits will be provided at the level for emergency care. Hospitals are open to treat an Emergency 24 hours a day, 7 days a week. Follow-up care is not considered emergency care.

Benefits are provided for treatment of emergency medical conditions and emergency screening and stabilization services without prior authorization for conditions that reasonably appear to a prudent layperson to constitute an emergency medical condition based upon the patient's presenting symptoms and conditions. Benefits for emergency care include facility costs, physician services, and supplies and prescriptions.

For Inpatient admissions following emergency care, prior authorization/precertification is not required. However, you must notify us or verify that your physician has notified us of your admission within 24 hours or as soon as possible within a reasonable period of time. When we are contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary.

Care and treatment provided once you are stabilized is not emergency care. Continuation of care from a non-network provider beyond that needed to evaluate or stabilize your condition in an emergency will be covered as non-network benefit unless we authorize the continuation of care and it is Medically Necessary.

Urgent Care Center Services

Often an urgent rather than an emergency medical problem exists. All Covered services obtained at urgent care centers are subject to the urgent care Copayment/Coinsurance. Urgent care services can be obtained from a network or non-network provider. However, you must obtain urgent care services from a network provider to receive maximum benefits. Urgent care services received from a non-network provider will be covered as a non-network service and you will be responsible for the difference between the non-network provider's charge and the Maximum Allowable Amount, in addition to any applicable Coinsurance, Copayment or Deductible. If you experience an accidental injury or a medical problem, this KYHC Plan will determine whether your injury or condition is an urgent care or emergency care situation for coverage purposes, based on your diagnosis and symptoms.

An urgent care medical problem is an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an emergency. Urgent care medical problems include, but are not limited to, ear ache, sore throat, and fever (not above 104 degrees). Treatment of an urgent care medical problem is not life threatening and does not require use of an emergency room at a hospital. If you call your physician prior to receiving care for an urgent medical problem and your physician authorizes you to go to an emergency room, your care will be paid at the level specified in the *Schedule of Benefits* for emergency room services. See your *Schedule of Benefits* for benefit limitations.

Endometriosis and Endometritis
Covered services include coverage for diagnosis and treatment of endometriosis and endometritis.

Home Care Services
See the *Schedule of Benefits* for any applicable Deductible, Coinsurance, Copayment, and benefit limitation information.

Covered services are those performed by a home health care agency or other provider in your residence, up to a maximum of 100 visits per year. Home health care includes professional,

technical, health aide services, supplies, and medical equipment. The Member must be confined to the home for medical reasons, and be physically unable to obtain needed medical services on an outpatient basis. Covered services include but are not limited to:

- Intermittent skilled nursing services (by an R.N. or L.P.N.)
- Medical/Social services.
- Diagnostic services.
- Nutritional Guidance.
- Home Health Aide services. The Member must be receiving skilled nursing or therapy. Services must be furnished by appropriately trained personnel employed by the home health care provider. Other organizations may provide services only when approved by us, and their duties must be assigned and supervised by a professional nurse on the staff of the home health care provider.
- Therapy Services (except for Manipulation Therapy which will not be covered when rendered in the home). Home care visit limits specified in the *Schedule of Benefits* for Home Care Services apply when therapy services are rendered in the home.
- Medical/Surgical supplies.
- Durable Medical Equipment.
- Prescription drugs (only if provided and billed by a home health care agency).
- Private Duty Nursing

Non-covered services include:

- Food, housing, homemaker services and home delivered meals.
- Home or outpatient hemodialysis services (these are covered under Therapy Services).
- Physician charges.
- Helpful environmental materials (hand rails, ramps, telephones, air conditioners, and similar services, appliances and devices.)
- Services provided by registered nurses and other health workers who are not acting as employees or under approved arrangements with a contracting home health care provider.
- Services provided by a member of the patient's immediate family.
- Services provided by volunteer ambulance associations for which patient is not obligated to pay, visiting teachers, vocational guidance and other counselors, and services related to outside, occupational and social activities.

Benefits for home infusion therapy may be subject to prior approval/authorization from us (if applicable). Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes but is not limited to:

- injections (intra-muscular, subcutaneous, continuous subcutaneous),
- Total Parenteral Nutrition (TPN),
- Enteral nutrition therapy,
- Antibiotic therapy,
- pain management and;
- chemotherapy

Hospice Services
See the *Schedule of Benefits* for any applicable Deductible, Coinsurance, Copayment, and Benefit limitation information.

Hospice care may be provided in the home or at a hospice facility where medical, social and psychological services are given to help treat patients with a terminal illness. Hospice services include routine home care, continuous home care, inpatient hospice and inpatient respite. To be eligible for hospice benefits, the patient must have a life expectancy of six (6) months or less, as confirmed by the attending physician. Covered services will continue if the Member lives longer than six (6) months.

When approved by your physician, Covered services include the following:

- Skilled nursing services (by an R.N. or L.P.N.)
- Diagnostic services
- Physical, speech and inhalation therapies if part of a treatment plan
- Medical supplies, equipment and appliances (benefits will not be covered for equipment when the Member is in a facility that should provide such equipment).
- Counseling services.
- Inpatient confinement at a hospice.
- Prescription drugs given by the hospice
- Home health aide

Non-covered services include:

- Services provided by volunteers.
- housekeeping services.

Inborn Errors of Metabolism or Genetic Conditions
See the *Schedule of Benefits* for any applicable Deductible, Coinsurance, Copayment, and benefit limitation information.

Covered services include coverage for the necessary care and treatment of medically diagnosed inborn errors of metabolism or genetic conditions.

Inpatient Services
See the *Schedule of Benefits* for any applicable Deductible, Coinsurance, Copayment, and benefit limitation information.

Inpatient services do not include care related to behavioral health services, except as specified. Refer to the section titled behavioral health Services for services covered by this KYHC Plan. Inpatient services include:

- Charges from a hospital, skilled nursing facility (SNF) or other provider for room, board and general nursing services.
- Ancillary (related) services.
- Professional services from a physician while an Inpatient.

Room, Board, and General Nursing Services

- A room with two or more beds.
- A private room. The private room allowance is the hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by us. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.

Ancillary (Related) Services

- Operating, delivery and treatment rooms and equipment.
- Prescribed drugs.
- Anesthesia, anesthesia supplies and services given by an employee of the hospital or other provider.
- Medical and surgical dressings, supplies, casts and splints
- Diagnostic services.
- Therapy services.

Professional Services

- Medical care visits limited to one visit per day by any one physician
- Intensive medical care for constant attendance and treatment when your condition requires it for a prolonged time.
- Concurrent care for a medical condition by a physician who is not your surgeon while you are in the hospital for surgery. Care by two or more physicians during one hospital stay when the nature or severity of your condition requires the skills of separate physicians.
- Consultation which is a personal bedside examination by another physician when requested by your physician. Staff consultations required by hospital rules; consultations requested by the patient; routine radiological or cardiographic consultations; telephone consultations; EKG transmittal via phone are excluded.
- Surgery and the administration of general anesthesia
- Newborn exam. A physician other than the physician who performed the obstetrical delivery must do the examination.

Second Opinions

A consultation with a Network health care provider for a second opinion may be obtained at the same Copayment/Coinsurance as any other service.

Maternity Services

See the *Schedule of Benefits* for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Maternity services include inpatient services, outpatient services and physician home visits and office services. These services are used for normal or complicated pregnancy, miscarriage, therapeutic abortion (abortion recommended by a provider), and ordinary routine nursery care for a healthy newborn. Abortion means the ending of a pregnancy before the birth of the infant. Miscarriage is a spontaneous abortion (occurs naturally and suddenly). A therapeutic abortion is one performed to save the life or health of the mother.

If the Member is pregnant on her effective date and is in the first trimester of the pregnancy, she must change to a Network provider to have covered services paid at the Network level. If the Member is pregnant on her effective date, benefits for obstetrical care will be paid at the Network level if the Member is in her second or third trimester of pregnancy (13 weeks or later) as of the effective date. Services will not be limited based upon the location of the labor and delivery.

Covered services will include the obstetrical care provided by that provider through the end of the pregnancy and the immediate post-partum period. The Member must complete a Continuation of Care Request Form and submit to us.

Coverage for the inpatient postpartum stay for you and your newborn child in a hospital will be, at a minimum, 48 hours for a vaginal delivery and 96 hours for a cesarean section, without prior authorization required. Coverage will be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Prenatal Care. Length of stay in a hospital begins at the time of delivery if delivery occurs in a hospital and at the time of admission in connection with childbirth, if delivery occurs outside the hospital.

Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if your attending physician determines further inpatient postpartum care is not necessary for you or your newborn child, provided the following are met and the mother concurs. In the opinion of your attending physician, the newborn child meets the criteria for medical stability in the Guidelines for Perinatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon evaluation of:

1. the antepartum, intrapartum, and postpartum course of the mother and infant;
2. the gestational stage, birth weight, and clinical condition of the infant;
3. the demonstrated ability of the mother to care for the infant after discharge; and
4. the availability of post-discharge follow-up to verify the condition of the infant after discharge.

Covered services include at-home post-delivery care visits at your residence by a physician or nurse performed no later than 72 hours following you and your newborn child's discharge from the hospital. Coverage for this visit includes, but is not limited to:

1. parent education;
2. assistance and training in breast or bottle feeding; and
3. performance of any maternal or neonatal tests routinely performed during the usual course of inpatient care for you or your newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.
   *At your discretion, this visit may occur at the physician's office**.**

Statement of Rights Under the Newborns' and Mothers' Health Protection Act
Under federal law, health insurance issuers may not 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 delivery by cesarean section. However, the issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse, midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, issuers 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.

In addition, an issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 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 prior authorization/precertification. For information on prior

authorization/precertification, contact us by calling the customer service telephone number on the back of your identification card.

- Covered services include one at-home post-delivery care visit is provided to you at your residence by a physician or nurse when performed no later than 72 hours following you and your newborn child's discharge from the hospital. Coverage for this visit includes:
    - Parent education
    - Physical assessments
    - Assessment of the home support system
    - Assistance and training in breast or bottle feeding
    - Performance of any maternal or neonatal tests routinely performed during the usual course of inpatient care for you or your newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.
      *In your discretion, this visit may occur at the physician's office.

Medical Supplies, Durable Medical Equipment, and Appliances

See the *Schedule of Benefits* for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

The supplies, equipment and appliances described below are covered services under this benefit. If the supplies, equipment and appliances include comfort, luxury, or convenience items or features which exceed what is Medically Necessary in your situation or needed to treat your condition, reimbursement will be based on the Maximum Allowable Amount for a standard item that is a covered service, serves the same purpose, and is Medically Necessary.

Any expense that exceeds the Maximum Allowable Amount for the standard item which is a covered service is your responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates your condition.

Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below may be covered, as approved by Us. The repair, adjustment or replacement of the purchased equipment, supply or appliance is covered if:

- The equipment, supply or appliance is a Covered Service;
- The continued use of the item is Medically Necessary;
- There is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).

In addition, replacement of purchased equipment, supplies or appliance may be covered if:

1. The equipment, supply or appliance is worn out or no longer functions.
2. Repair is not possible or would equal or exceed the cost of replacement. An assessment by a rehabilitation equipment specialist or vendor should be done to estimate the cost of repair.
3. Member’s needs have changed and the current equipment is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
4. The equipment, supply or appliance is damaged and cannot be repaired.

Benefits for repairs and replacement do not include the following:

- Repair and replacement due to misuse, malicious breakage or gross neglect.
- Replacement of lost or stolen items.

We may establish reasonable quantity limits for certain supplies, equipment or appliance described below. A detailed listing of supplies, equipment or appliances that are not covered by us including quantity limits, is available to you upon request. Please call the customer service number on your identification card. This list is subject to change.

Covered services may include, but are not limited to:

- **Medical and surgical supplies**: Certain supplies and equipment for the management of disease that we approve are covered under the prescription drug benefit. These supplies may otherwise be considered as a medical supply benefit if the supplies, equipment or appliances are not received from the PBM's mail service or from a Network pharmacy. Syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose. Covered services also include prescription drugs and biologicals that cannot be self-administered and are provided in a physician's office. Covered services do not include items usually stocked in the home for general use like thermometers and petroleum jelly.

  Covered services may include, but are not limited to:
  1. Allergy serum extracts
  2. Chem strips, Glucometer, Lancets
  3. Clinitest
  4. Needles/syringes
  5. Ostomy bags and supplies except charges such as those made by a pharmacy for purposes of a fitting are not covered services.
  6. Contraceptive devices including diaphragms, intra uterine devices (IUDs), and implants.

  Non-covered services include:
  1. Adhesive tape, band aids, gauze, cotton tipped applicators
  2. Arch supports
  3. Doughnut cushions
  4. Hot packs, ice bags
  5. Vitamins
  6. Medijectors

  If you have any questions regarding whether a specific medical or surgical supply is covered or want to obtain a detailed list, call the customer service number on the back of your identification card.

- **Durable medical equipment:** The rental (or, at our option, the purchase) of durable medical equipment prescribed by a physician or other provider. Durable medical equipment is equipment which can withstand repeated use; i.e., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; is not useful to a person in the absence of illness or injury; and is appropriate for use in a patient's home. Examples include but are not limited to:
  1. wheelchairs
  2. crutches

3. hospital beds and,
4. oxygen equipment.

Rental costs must not be more than the purchase price. This KYHC Plan will not pay for rental for a longer period of time than it would cost to purchase equipment. The cost for delivering and installing the equipment are covered services. Payment for related supplies is a covered service only when the equipment is a rental, and medically fitting supplies are included in the rental; or the equipment is owned by the Member; medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is covered.

Covered services may include, but are not limited to:
1. Hemodialysis equipment
2. Crutches and replacement of pads and tips
3. Pressure machines
4. Infusion pump for IV fluids and medicine
5. Glucometer
6. Tracheotomy tube
7. Cardiac, neonatal and sleep apnea monitors
8. Augmentive communication devices are covered when we approve based on the Member's condition.

Non-covered items include:
1. Air conditioners
2. Ice bags/cold-pack pump
3. Raised toilet seats
4. Rental of equipment if the you are in a facility that is expected to provide such equipment
5. Trans-lift chairs
6. Treadmill exerciser
7. Tub chair used in shower.

If you have any questions regarding whether specific durable medical equipment is covered or want to obtain a detailed list, call the customer service number on the back of your identification card

- **Prosthetics**: Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that:
  1. Replace all or part of a missing body part and its adjoining tissues; or
  2. Replace all or part of the function of a permanently useless or malfunctioning body part.

  Prosthetic devices should be purchased not rented, and must be Medically Necessary. Applicable taxes, shipping and handling are also covered.

  Covered services may include, but are not limited to:
  1. Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular

reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
2. Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
3. Breast prostheses whether internal or external, following a mastectomy, and four surgical bras per benefit period, as required by the Women's Health and Cancer Rights Act. Maximums for prosthetic devices, if any, do not apply.
4. Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.
5. Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are covered services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of surgery are not considered contact lenses, and are not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the Member selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.
6. Cochlear implant.
7. Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
8. Restoration prosthesis (composite facial prosthesis)
9. Wigs (the first one following cancer treatment, not to exceed one per annual benefit period).
10. Hearing Aids - Any device or instrument that can be worn repeatedly provided the device is\ provided to a Member under 18 years of age no more than one time per hearing impaired ear every thirty-six (36) months.

Non-covered prosthetic appliances include:
1. Dentures, replacing teeth or structures directly supporting teeth.
2. Dental appliances.
3. Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets.
4. Artificial heart implants.
5. Wigs (except as described above following cancer treatment).
6. Penile prosthesis in men suffering impotency resulting from disease or injury.

If you have any questions regarding whether a specific prosthetic is covered or want to obtain a detailed list, call the customer service number on the back of your identification card

- **Orthotic devices**: Covered services are the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are included. Applicable tax, shipping, postage and handling charges are also covered. The casting is covered when an orthotic appliance is billed with it, but not if billed separately.

Covered orthotic devices may include, but are not limited to, the following:

1. Cervical collars.
2. Ankle foot orthosis.
3. Corsets (back and special surgical).
4. Splints (extremity)
5. Trusses and supports.
6. Slings.
7. Wristlets.
8. Built-up shoe.
9. Custom made shoe inserts.

Orthotic appliances may be replaced once per year per Member when Medically Necessary in your situation. However, additional replacements will be allowed for those of you under age 18 due to rapid growth, or for any of you when an appliance is damaged and cannot be repaired.

Non-covered services include:

1. Orthopedic shoes (except therapeutic shoes for diabetics)
2. Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace.
3. Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under Medical Supplies).
4. Garter belts or similar devices.

If you have any questions regarding whether a specific orthotic is covered or want to obtain a detailed list, call the customer service number on the back of your identification card.

- **Outpatient Services**

  See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and benefit limitation information.

  Outpatient services include facility, ancillary, facility use, and professional charges when given as an outpatient at a hospital, alternative care facility, retail health clinic, or other provider as determined by this KYHC Plan. These facilities may include a non-hospital site providing diagnostic and therapy services, surgery, or rehabilitation, or other provider facility as determined by us. Outpatient services do not include care that is related to behavioral health services, except as otherwise specified. Refer to the section titled behavioral health services for services covered by this KYHC plan. Professional charges only include services billed by a physician or other professional.

  When diagnostic services or other therapy services, (chemotherapy, radiation, dialysis, inhalation, or cardiac rehabilitation), is the only outpatient services charge, no Copayment is required if received as part of an outpatient surgery. Any Coinsurance will still apply to these services. For emergency accident or medical care refer to the emergency care and urgent care section.

  For Emergency Accident or Medical Care, refer to the "Emergency Care and Urgent Care" section.

Physician Home Visits and Office Services

See the *Schedule of Benefits* for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered services include care provided by a physician in their office or your home. Refer to the sections titled "Preventive Care", "Maternity Care", "Home Care Services" and "Behavioral Health Services other than Biologically Based Mental Illness" for services covered by this KYHC plan. For emergency care refer to the ”Emergency Care and Urgent Care” section.

- **Office visits** for medical care and consultations to examine, diagnose, and treat an illness or injury performed in the physician’s office. Office visits also include allergy testing, injections and serum. When allergy serum is the only charge from a physician’s office, no Copayment is required. Coinsurance is not waived.
- **Home Visits** for medical care and consultations to examine, diagnose, and treat an illness or injury performed in your home.
- **Diagnostic Services** when required to diagnose or monitor a symptom, disease or condition.
- **Surgery and Surgical Services** (including anesthesia and supplies). The surgical fee includes normal post-operative care.
- **Therapy Services** for physical medicine therapies and other therapy services when given in the office of a physician or other professional provider.
- **Online clinic visits**: When available in your area, your coverage will include online clinic visit services. 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.

  Non-covered services include communications used for:
  1. Reporting normal lab or other test results
  2. Office appointment requests
  3. Billing, insurance coverage or payment questions
  4. Requests for referrals to doctors outside the online care panel
  5. Benefit precertification
  6. Physician to physician consultation

Preventive Care Services
See the *Schedule of Benefits* for any applicable Deductible, Coinsurance, Copayment, and benefit limitation information.

Note: Preventive care services in this section shall meet requirements as determined by federal law. Many preventive care services are covered by this contract with no Deductible, Copayments or Coinsurance from the Member when provided by a Network provider. That means we pay 100% of the Maximum Allowed Amount. These services fall under four 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. This includes generic drugs only, unless there is no generic equivalent, obtained from a Network pharmacy, as well as injectable contraceptives and patches, contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. When generic equivalents are available, prescription brand name contraceptives will not be covered under the preventive care benefit. Instead, prescription contraceptives not covered under Preventive Care will be considered for benefits under the Prescription Drug benefit as described in the "Prescription Drugs" section.
    b. Breastfeeding support, supplies, and counseling. To obtain Network benefit breast pumps and supplies must be received from Our Network Provider. If another provider is used, benefits will be covered as Non-Network. Breast pumps are limited to one per calendar year, or as required by law.
    c. Gestational diabetes screenings.

You may call customer service using the number on your ID card for additional information about these services.

Covered services also include the following services required by state and federal law:

- Routine bone density testing for women.
- Routine screening mammograms including coverage for low-dose mammography screening.
- Routine colorectal cancer examination and related laboratory tests.
- Pelvic examinations

Other covered services are:

- Routine hearing screenings
- Routine vision screenings

Surgical Services
See the *Schedule of Benefits* for any applicable Deductible, Coinsurance, Copayment, and benefit limitation information.

Coverage for surgical services when provided as part of physician home visits and office services, inpatient services, or outpatient services includes but is not limited to:

- Performance of accepted operative and other invasive procedures;
- The correction of fractures and dislocations;
- Anesthesia and surgical assistance when Medically Necessary;
- Usual and related pre-operative and post-operative care;
- Cochlear implants;

- Other procedures as approved by us.

The surgical fee includes normal post-operative care. We may combine the reimbursement when more than one surgery is performed during the same operative session. Contact us for more information.

Covered surgical services include, but are not limited to: •

- Operative and cutting procedures;
- Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy;
- Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine

Post Mastectomy Services
A Member who is receiving benefits for a covered mastectomy or for follow-up care in connection with a covered mastectomy, and who elects breast reconstruction, will also receive coverage for:

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

Reconstructive Services
Certain reconstructive services required to correct a deformity caused by disease, trauma, congenital anomalies, or previous therapeutic process are covered. Reconstructive services required due to prior therapeutic process are payable only if the original procedure would have been a covered service under this KYHC Plan. Covered services are limited to the following:

- Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of a newborn child.
- Breast reconstruction resulting from a mastectomy. See 'Post-Mastectomy Services" above for further coverage details.
- Hemangiomas, and port wine stains of the head and neck areas for children ages 18 years of age or younger;
- Limb deformities such as club hand, club foot, syndactyly (webbed digits), polydactyly (supernumerary digits), macrodactylia;
- Otoplasty when performed to improve hearing by directing sound in the ear canal, when ear or ears are absent or deformed from trauma, surgery, disease, or congenital defect;
- Tongue release for diagnosis of tongue-tied;
- Congenital disorders that cause skull deformity such as Crouzon's disease;
- Cleft lip;
- Cleft palate.

Sterilization
Sterilization is a covered service. Sterilizations for women will be covered under the "Preventive Care" benefit. Please see that section for further details.

Tele-health Consultation Services
See the *Schedule of Benefits* for any applicable Deductible, Coinsurance, Copayment, and

benefit limitation information.

Covered services include a medical or health consultation, for purposes of patient diagnosis or treatment that requires the use of advanced telecommunications technology, including, but not limited to:

- Compressed digital interactive video, audio, or data transmission;
- Clinical data transmission via computer imaging for teleradiology or telepathology; and
- Other technology that facilitates access to other covered health care services or medical specialty expertise.

Temporomandibular or craniomandibular Joint Disorder and Craniomandibular Jaw Disorder
See the *Schedule of Benefits* for any applicable Deductible, Coinsurance, Copayment, and benefit limitation information.

Benefits are provided for surgical and nonsurgical treatment of Medically Necessary temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and craniomandibular (head and neck muscle) joint disorders.

Therapy Services
See the *Schedule of Benefits* for any applicable Deductible, Coinsurance, Copayment, and benefit limitation information.

When therapy services are given as part of physician home visits and office services, inpatient services, outpatient services, or home care services, coverage for these therapy services is limited to the following:

- **Physical Medicine Therapy Services**
  The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time.

- **Physical therapy** including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part. non-covered services include: maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness; repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients); range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities; general exercise programs; diathermy, ultrasound and heat treatments for pulmonary conditions; diapulse; work hardening.

- **Speech therapy** for the correction of speech impairment.

- **Occupational therapy** for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not

include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts). Non-covered services include: supplies (looms, ceramic tiles, leather, utensils); therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again; general exercises to promote overall fitness and flexibility; therapy to improve motivation; suction therapy for newborns (feeding machines); soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial; adaptions to the home such as ramp ways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.

- **Manipulation Therapy** includes osteopathic/chiropractic manipulation therapy used for treating problems associated with bones, joints and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy includes equal emphasis on the joints and surrounding muscles, tendons and ligaments. Manipulations whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward any maximum for manipulation therapy services as specified in the *Schedule of Benefits*. Manipulation therapy services rendered in the home as part of home care services are not covered.

- **Other Therapy Services**
    - **Cardiac rehabilitation** to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not covered.
    - **Chemotherapy** for the treatment of a disease by chemical or biological antineoplastic agents, including the cost of such agents.
    - **Dialysis treatments** of an acute or chronic kidney ailment which may include the supportive use of an artificial kidney machine.
    - **Radiation therapy** for the treatment of disease by X-ray, radium, or radioactive isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources); materials and supplies used in therapy; treatment planning.
    - **Inhalation therapy** for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation. Covered services include but are not limited to, introduction of dry or moist gases into the lungs; non-pressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with our without nebulized medication; continuous positive airway pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.
    - **Pulmonary rehabilitation** to restore an individual's functional status after an illness or injury. Covered services include but are not limited to outpatient short-term respiratory services for conditions which are expected to show significant improvement through short-term therapy. Also covered is inhalation therapy administered in physician's office including but are not limited to breathing exercise, exercise not elsewhere classified, and other counseling. Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a covered service.

Physical Medicine and Rehabilitation Services

A structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patient's ability to function as independently as possible; including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and services of a social worker or psychologist. The goal is to obtain practical improvement in a reasonable length of time in the appropriate Inpatient setting.

Physical medicine and rehabilitation involves several types of therapy, not just physical therapy, and a coordinated team approach. The variety and intensity of treatments required is the major differentiation from an admission primarily for physical therapy.

Non-covered services for physical medicine and rehabilitation include:

- admission to a hospital mainly for physical therapy;
- long-term rehabilitation in an Inpatient setting.

Day Rehabilitation Program services provided through a day hospital for physical medicine and rehabilitation are covered services. A Day Rehabilitation Program is for those patients who do not require Inpatient care but still require a rehabilitation therapy program four to eight hours a day,2 or more days a week at a day hospital. Day rehabilitation program services may consist of physical therapy, Occupational Therapy, Speech Therapy, nursing services, and neuropsychological services. A minimum of two Therapy Services must be provided for this program to be a Covered Service.

Certain therapy services rendered on an inpatient or an outpatient basis are limited. See the *Schedule of Benefits*.

Vision Services

Benefits are available for medical and surgical treatment of injuries and/or diseases affecting the eye. Routine vision exams required by federal law are covered under the "*Preventive Care*" benefit. Benefits for other covered services are based on the setting in which services are received. Benefits are not available for glasses and contact lenses except as described in the "*Prosthetics*" benefit.

Additional covered services include:

- Determination of refraction,
- Routine Ophthalmological examination including refraction for new and established patients, and
- A visual functional screening for visual acuity.

These additional services are not part of the "*Preventive Care*" benefit and will be based on the setting which services are received. No additional ophthalmological services are covered, except as described above.

Human Organ and Tissue Transplant Services

See the *Schedule of Benefits* for any applicable Deductible, Copayment, Coinsurance, and Benefit limitation information.

The human organ and tissue transplant (bone marrow/stem cell) services benefits or requirements described below do not apply to the following:

- Cornea and kidney transplants; and
- Any covered services, related to a covered transplant procedure, received prior to or after the transplant benefit period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your provider and the harvest and storage of bone marrow / stem cells is included in the covered transplant procedure benefit regardless of the date of service.

The above services are covered as inpatient services, outpatient services or physician home visits and office services depending where the service is performed, subject to applicable Member cost shares.

Covered Transplant Procedure
Any Medically Necessary human organ and stem cell/bone marrow transplants and transfusions as determined by Us, including necessary acquisition procedures, harvest and storage, and including Medically Necessary preparatory myeloablative therapy.

Covered transplant procedures include treatment of breast cancer by high-dose chemotherapy with autologous bone marrow transplantation or stem cell transplantation.

Transplant Benefit Period

- **Network Transplant Provider**: 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 the case manager for specific Network transplant provider information for services received at or coordinated by a Network transplant provider facility.

- **Non-Network Transplant Provider**: Starts one day prior to a covered transplant procedure and continues to the date of discharge at a non-network transplant provider facility.

Prior Approval and Precertification
In order to maximize your benefits, we strongly encourage you to call our 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. We 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 we issue a prior approval for the covered transplant procedure, you or your provider must call our transplant department for precertification prior to the transplant whether this is performed in an inpatient or outpatient setting.

Please note that there are instances where your provider requests approval for HLA testing, donor searches and/or a harvest 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 harvest 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 harvest 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
This KYHC Plan will provide assistance with reasonable and necessary travel expenses as determined by us 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. Our assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two (2) companions. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to Us when claims are filed. Contact us at the customer service number listed on your identification card for detailed information. For lodging and ground transportation benefits, we will provide a maximum benefit up to the current limits set forth in the Internal Revenue Code.

Non-covered services for transportation and lodging include the following:

- Child care,
- Mileage within the medical transplant facility city,
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by us;
- Frequent flyer miles,
- Coupons, vouchers, or travel tickets,
- Prepayments or deposits,
- Services for a condition that is not directly related, or a direct result, of the transplants
- Telephone calls,
- Laundry,
- Postage,
- Entertainment,
- Interim visits to a medical care facility while waiting for the actual transplant procedure,
- Travel expenses for donor companion/caregiver,
- Return visits for the donor for a treatment of a condition found during the evaluation.

Certain human organ and tissue transplant services may be limited. *See the Schedule of Benefits*.

Prescription Drug Benefits
See the *Schedule of Benefits* for any applicable Deductible, Coinsurance, Copayment, and Benefit limitation information. One drug in every United states Pharmacopeia (USP) category and class; or the same number of prescription drugs in each category and class as the Kentucky EHB-Benchmark plan.

Pharmacy Benefits Manager
The pharmacy benefits available to you under this contract are managed by our Pharmacy Benefits Manager (PBM). The PBM is a pharmacy benefits management company with which we contract to manage your pharmacy benefits. The PBM has a nationwide network of retail

pharmacies, a mail service pharmacy, a Specialty pharmacy, and provides clinical management services.

The management and other services the PBM provides include, among others, making recommendations to, and updating, the covered prescription drug list (also known as a Formulary) and managing a network of retail pharmacies and, operating a mail service pharmacy, and a specialty drug pharmacy network. The PBM, in consultation with us, also provides services to promote and enforce the appropriate use of pharmacy benefits, such as review for possible excessive use; recognized and recommended dosage regimens; Drug interactions or drug/pregnancy concerns.

You may request a copy of the covered prescription drug list by calling the customer service telephone number on the back of your identification card. The covered prescription drug list is subject to periodic review and amendment. Inclusion of a drug or related item on the covered prescription drug list is not a guarantee of coverage.

Prescription drugs, unless otherwise stated below, must be Medically Necessary and not Experimental or Investigative, in order to be covered services. For certain prescription drugs, the prescribing physician may be asked to provide additional information before the PBM and/or this KYHC Plan can determine Medical Necessity. This KYHC Plan may establish quantity and/or age limits for specific prescription drugs which the PBM will administer. Covered services will be limited based on Medical Necessity, quantity and/or age limits established by this KYHC Plan, or utilization guidelines.

Prior authorization may be required for certain prescription drugs (or the prescribed quantity of a particular drug). Prior authorization helps promote appropriate utilization and enforcement of guidelines for prescription drug benefit coverage. At the time you fill a prescription, the Network pharmacist is informed of the prior authorization requirement through the pharmacy's computer system. The PBM uses pre-approved criteria, developed by our KYHC Pharmacy and Therapeutics Committee which is reviewed and adopted by us. We or the PBM, may contact your provider if additional information is required to determine whether prior authorization should be granted. We communicate the results of the decision to both you and your provider.

If prior authorization is denied, you have the right to appeal through the appeals process outlined in the Complaint and Appeals Procedure section of this contract. For a list of the current drugs requiring prior authorization, please contact the customer service telephone number on the back of your ID card.

The covered prescription drug list is subject to periodic review and amendment. Inclusion of a drug or related item on the covered prescription drug list is not a guarantee of coverage under your contract. Refer to the prescription drug benefit sections in this contract for information on coverage, limitations and exclusions. Your provider or Network pharmacist may check with us to verify covered prescription drugs, any quantity and/or age limits, or applicable brand or generic drugs recognized under this KYHC Plan.

Therapeutic Substitution of Drugs
A program approved by us and managed by the PBM. This is a voluntary program designed to inform Members and physicians about possible alternatives to certain prescribed drugs. We, or the PBM, may contact you and your prescribing physician to make you aware of substitution options. Therapeutic substitution may also be initiated at the time the prescription is dispensed.

Only you and your physician can determine whether the therapeutic substitute is appropriate for you. For questions or issues involving therapeutic drug substitutes, call the customer service telephone number on the back of your ID card. The therapeutic drug substitutes list is subject to periodic review and amendment.

Step Therapy
Step therapy protocol means that you may need to use one type of medication before another. The PBM monitors some prescription drugs to control utilization, to ensure that appropriate prescribing guidelines are followed, and to help you access high quality, yet cost effective, prescription drugs. If a physician decides that the monitored medication is needed, the physician will need to submit a letter fax including the following details:

- Member name and ID number:
- Diagnosis;
- Drug name;
- Reason for appeal;
- Physician name, specialty, address and phone number.

Specialty Pharmacy Network
The PBM's Specialty Pharmacy Network is available to members who use specialty drugs.

"Specialty Drugs" are prescription legend drugs which:

- Are only approved to treat limited patient populations, indications or conditions; or
- Are normally injected, infused or require close monitoring by a physician or clinically trained individual; or
- Have limited availability, special dispensing and delivery requirements, and/or require additional patient support – any or all of which make the drug difficult to obtain through traditional pharmacies.

Network specialty pharmacies may fill both retail and mail service specialty drug prescription orders, subject to a day supply limit for retail and mail service, and subject to the applicable Coinsurance or Copayment shown in the *Schedule of Benefits*. Network specialty pharmacies have dedicated patient care coordinators to help you manage your condition and offer toll-free twenty-four hour access to nurses and registered pharmacists to answer questions regarding your medications.

You may obtain a list of the Network specialty pharmacies, and covered specialty drugs, by calling the customer service telephone number on the back of your ID card, or review the lists on our website at www.mykyhc.org.

Note: In order to be covered, specialty drugs must be purchased from a Network specialty pharmacy.

Your Prescription Drug Benefits
Your prescription drug program provides benefits for the generic drugs and brand name drugs listed on the KYHC formulary. This formulary is a prescription drug list that includes generic drugs and select brand name alternatives in many therapeutic classes.

Only the prescription drugs listed on your KYHC formulary are covered.

Specialty drugs that are listed on your KYHC formulary are covered also, only when purchased from a specialty pharmacy in your Network.

Please note that the drugs listed on your KYHC formulary are subject to periodic review and revision. For the most recent KYHC formulary, go to call the customer service telephone number on your ID card.

Tiers :Your Copayment/Coinsurance amount may vary based on whether the prescription drug, including covered specialty drugs, has been classified by us as a first, second, third, or fourth "tier" drug. The determination of tiers is made by us based upon:

a. clinical information, and where appropriate the cost of the drug relative to other drugs in its therapeutic class or used to treat the same or similar condition;
b. the availability of over-the-counter alternatives; and where appropriate certain clinical economic factors.

Tier 1: Prescription drugs have the lowest Coinsurance or Copayment. This tier will contain low cost and preferred medications, usually preferred Generic drugs but may include specific single-source brands and other specific brand name drugs.

Tier 2: Prescription drugs will have a higher Coinsurance or Copayment than those in Tier 1. This tier will contain preferred Brand medications but may also include specific Generic drugs

Tier 3: Prescription drugs will have a higher Coinsurance or Copayment than those in Tier 2. This tier will contain non-preferred and high cost medications. This will include medications considered Generic, single source brands, and multi-source brands.

Tier 4: Prescription drugs will have a higher Coinsurance than those in Tier 3. This tier will contain all forms of specialty drugs and specific other brand drugs.

Tier and Formulary Assignment Process

We have established a Pharmacy and Therapeutics (P&T) Committee, consisting of health care professionals, including nurses, pharmacists, and physicians. The purpose of this committee is to assist in determining clinical appropriateness of drugs; determining the tier assignments of drugs; and advising on programs to help improve care. Such programs may include, but are not limited to, drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, drug profiling initiatives and the like.

The determinations of tier assignments and formulary inclusion are made by us based upon clinical decisions provided by the P&T Committee, and where appropriate, the cost of the drug relative to other drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; generic availability, the degree of utilization of one drug over another in our patient population, and where appropriate, certain clinical economic factors.

We retain the right at our discretion to determine coverage for dosage formulations in terms of covered dosage administration methods (for example, by mouth, injections, topical, or inhaled) and may cover one form of administration and exclusion or place other forms of administration in another tier.

Covered Prescription Drug Benefits

- Prescription legend drugs.
- Specialty drugs.
- Injectable insulin and syringes used for administration of insulin.
- Certain supplies and equipment obtained by mail service or from a Network pharmacy (such as those for diabetes and asthma) are covered without any Copayment or Coinsurance. Contact us to determine approved covered supplies. If certain supplies, equipment or appliances are not obtained by mail service or from a Network pharmacy then they are covered as Medical Supplies, Equipment and Appliances instead of under prescription drug benefits.
- Injectables.
- Covered prescription drugs include therapeutic food, formulas, supplements, and low-protein modified food products for the treatment of inborn errors of metabolism or genetic conditions if the therapeutic food, formulas, supplements, and low-protein modified food products are obtained for the therapeutic treatment of inborn errors of metabolism or genetic conditions under the direction of a physician. Benefits available for their use are limited to conditions required by law. Prior authorization is required.
- Contraceptive drugs, including injectable contraceptive drugs and patches, are covered when obtained through an eligible Pharmacy. Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for further details.
- Certain prescription legend drugs may be covered services if an over the counter equivalent exists. This list is subject to change on a semiannual basis. Please check our website at www.mykyhc.org for the most current listing of medications.
- Prescription drugs to eliminate or reduce dependency on, or addiction to tobacco and tobacco products.

Non-covered Prescription Drugs (please also see Exclusions section of this Contract for other non-covered services)

- Prescription drugs dispensed by any mail service program other than the PBM's mail service, unless prohibited by law.
- Drugs, devices and products, or prescription legend drugs with over the counter equivalents and any drugs, devices or products that are therapeutically comparable to an over the counter drug, device, or product.
- Off label use, except as otherwise prohibited by law or as approved by us or the PBM.
- Drugs in quantities exceeding the quantity prescribed, or for any refill dispensed later than one year after the date of the original prescription order.
- Drugs not approved by the FDA.
- Charges for the administration of any drug.
- Drugs consumed at the time and place where dispensed or where the prescription order is issued, including samples provided by a physician. This does not apply to drugs used in conjunction with a diagnostic service, with chemotherapy performed in the office or drugs eligible for coverage under the *Medical Supplies* benefit; they are Covered services.
- Any drug which is primarily for weight loss.
- Drugs not requiring a prescription by federal law (including drugs requiring a prescription by state law, but not by federal law), except for injectable insulin.
- Drugs in quantities which exceed the limits established by this KYHC Plan, or which exceed any age limits established by us.

- Drugs for treatment of sexual or erectile dysfunctions or inadequacies, regardless of origin or cause.
- Fertility drugs
- Specialty drugs purchased at a non-network pharmacy.
- Any new FDA approved drug product or technology (such as medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, such as pharmacies, for the first six months after the product or technology received FDA new drug approval or other applicable FDA approval. This KYHC Plan may waive this exclusion in whole or in part for a specific new FDA approved drug product or technology.
- Human Growth Hormone for children born small for gestational age. It is only a covered service in other situations when allowed by us through prior authorization.
- Compound drugs unless there is at least one ingredient that requires a prescription.
- Refills of lost or stolen medications.
- Treatment of Onchomycosis (toenail fungus).
- Certain prescription legend drugs are not covered services when any version or strength becomes available over the counter. Please contact us for additional information on these drugs.
- Oral immunizations,
- Certain prescription drugs may not be covered when clinically equivalent alternatives are available. "Clinically equivalent" means drugs that, for the majority of members, can be expected to produce similar therapeutic outcomes for a disease or condition. If you have questions regarding whether a particular drug is covered and which drugs fall into this category, please call the member services number on the back of your identification card,

Deductible/Copayment/Coinsurance
Each prescription order may be subject to a Deductible and Coinsurance/Copayment. If the prescription order includes more than one covered drug, a separate Coinsurance/Copayment will apply to each covered drug. Your prescription drug Coinsurance/Copayment will be the lesser of your scheduled Copayment/Coinsurance amount or the Maximum Allowable Amount. Please see the Schedule of Benefits for any applicable Deductible and Coinsurance/Copayment.

If you receive covered services from a non-network pharmacy, a Deductible and Coinsurance/Copayment amount may also apply.

Generic Drug Encouragement
We may, from time to time, offer incentives to encourage the use of generic drugs. This may involve waiving a Copayment/Coinsurance for certain generic drugs for a period of time, or other incentives.

Half-Tablet Program
The Half-Tablet Program will allow Members to pay a reduced Copayment on selected “once daily dosage” medications. The Half-Tablet Program allows a Member to obtain a 30-day supply (15 tablets) of the higher strength medication when written by the physician to take “1/2 tablets daily” of those medications on the approved list. The Pharmacy and Therapeutics Committee will determine additions and deletions to the approved list. The Half-Tablet Program is strictly voluntary and the Member’s decision to participate should follow consultation with and the

agreement of his/her physician. To obtain a list of the products available on this program contact the number on the back of your ID card.

Days Supply
The number of days supply of a drug which you may receive is limited. The days supply limit applicable to prescription drug coverage is shown in the Schedule of Benefits. If you are going on vacation and you need more than the days supply allowed for under this contract, you should ask your pharmacist to call the PBM and request an override for one additional refill. This will allow you to fill your next prescription early. If you require more than one extra refill, please call the customer service telephone number on the back of your identification card.

Payment of Benefits
The amount of benefits paid is based upon whether you receive the Covered services from a Network pharmacy, including a Network specialty pharmacy, a non-network pharmacy, or the PBM's Mail Service Program. It is also based upon which Tier we have classified the prescription drug or specialty drug. Please see the *Schedule of Benefits* for the applicable amounts, and for applicable limitations on number of days supply.

We retain the right at our discretion to determine coverage for dosage formulations in terms of covered dosage administration methods (for example by mouth, injections, topical or inhaled) and may cover one form of administration and exclude other forms of administration on other Tiers.

The amounts for which you are responsible are shown in the *Schedule of Benefits*. No payment will be made by us for any covered service unless the negotiated rate exceeds any applicable Deductible and/or Copayment/Coinsurance for which you are responsible.

Your Copayment(s)/Coinsurance and/or Deductible amounts will not be reduced by any discounts, rebates or other funds received by the PBM and/or this KYHC Plan from drug manufacturers or similar vendors. For covered services provided by a Network or specialty drug Network pharmacy or through the mail service used by KYHC, you are responsible for all Deductibles and/or Copayment/Coinsurance amounts.

For covered services provided by a Network or specialty drug Network pharmacy or through the PBM's mail service, you are responsible for all Deductibles and/or Copayment/Coinsurance amounts. For covered services provided by a non-network pharmacy, you will be responsible for the amount(s) shown in the *Schedule of Benefits*. This is based on the Maximum Allowable Amount.

How to Obtain Prescription Drugs
How you obtain your benefits depends upon whether you go to a Network or a non-network or specialty drug Network pharmacy.

- **Network Pharmacy**: Present your written prescription order from your physician and your identification card to the pharmacist at a network pharmacy. The pharmacy will file your claim for you. You will be charged at the point of purchase for applicable Deductible and/or Copayment/Coinsurance amounts. If you do not present your identification card, you will have to pay the full retail price of the prescription. If you do pay the full charge, ask your pharmacist for an itemized receipt and submit it to us with a written request for refund.

- **Specialty Drugs**: You or your physician can order your specialty drugs directly from a specialty network pharmacy, simply call the customer service telephone number on the back of your ID card. If you or your physician orders your specialty drugs from a specialty network pharmacy you will be assigned a patient care coordinator who will work with you and your physician to obtain prior authorization and to coordinate the shipping of your specialty drugs directly to you or your physician's office. Your patient care coordinator will also contact you directly when it is time to refill your specialty drug prescription.

- **Non-Network Pharmacy** – You are responsible for payment of the entire amount charged by the non-network pharmacy, including a non-network specialty pharmacy. You must submit a prescription drug claim form for reimbursement consideration. These forms are available from the PBM. You must complete the top section of the form and ask the non-network pharmacy to complete the bottom section. If for any reason the bottom section of this form cannot be completed by the pharmacist, you must attach an itemized receipt to the claim form and submit to us or the PBM. The itemized receipt must show:
    - name and address of the non-network pharmacy;
    - patient's name;
    - prescription number;
    - date the prescription was filled;
    - name of the drug;
    - cost of the prescription;
    - quantity of each covered drug or refill dispensed.

You are responsible for the amount shown in the Schedule of Benefits. This is based on the Maximum Allowable Amount as determined by KYHC or the PBM's normal or average contracted rate with network pharmacies on or near the date of service.

- **The PBM's Mail Service**: Complete the Order and Patient Profile Form. You will need to complete the patient profile information only once. You may mail written prescriptions from your physician, or have your physician fax the prescription to the mail service. Your physician may also phone in the prescription to the mail service pharmacy. You will need to submit the applicable Deductible and/or Coinsurance and/or Copayment amounts to the mail service when you request a prescription or refill.

EXCLUSIONS/ (NON-COVERED SERVICES)

The following section indicates items which are excluded from benefit consideration, and are not considered covered services. Excluded items will not be covered even if the service, supply, or equipment would otherwise be considered Medically Necessary. Our medical policy guidelines will be used to determine if services or supplies are Medically Necessary. This information is provided as an aid to identify certain common items which may be misconstrued as covered services.

We do not provide benefits for procedures, equipment, services, supplies or charges:

1. Which we determine are not Medically Necessary or do not meet our medical policy, clinical coverage guidelines, or benefit policy guidelines.
2. Received from an individual or entity that is not a provider, as defined in this contract, or recognized by us.
3. Which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by us. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if we deem it to be Experimental/Investigative.
4. For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Workers' Compensation Act or other similar law. If Workers' Compensation Act benefits are not available to you, then this Exclusion does not apply. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.
5. To the extent that they are provided as benefits by any governmental unit.
6. For any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared.
7. For a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.
8. For care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs if the Member has been convicted as a felon. This exclusion does not apply to a Member while incarcerated in a local penal institution or in the custody of a local law enforcement officer prior to conviction for a felony.
9. For court ordered testing or care unless Medically Necessary.
10. For which you have no legal obligation to pay in the absence of this or like coverage.
11. For the following:
    a. Physician or other practitioners' charges for consulting with Members by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Member except as otherwise described in this contract in "Tele-health section.".
    b. Surcharges for furnishing and/or receiving medical records and reports.
    c. Charges for doing research with providers not directly responsible for your care.
    d. Charges that are not documented in provider records.
    e. Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending physician. For membership, administrative, or access fees charged by physicians or other providers. Examples of administrative fees include fees charged for educational brochures or calling a patient to provide their test results.
12. Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.
13. Prescribed, ordered or referred by or received from a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
14. For completion of claim forms or charges for medical records or reports.
15. For missed or canceled appointments.
16. For mileage, lodging and meals costs, and other Member travel related expenses, except as authorized by us or specifically stated as a covered service.
17. Charges in excess of our Maximum Allowable Amounts.
18. Incurred prior to your effective date.

19. Incurred after the termination date of this coverage except as specified elsewhere in this contract.
20. For any procedures, services, equipment or supplies provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve your appearance or are furnished for psychiatric or psychological reasons. No benefits are available for surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts). Complications directly related to cosmetic services treatment or surgery, as determined by us, is not covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Member was covered by another carrier/self-funded plan prior to coverage under this contract. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including: myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions.
21. For maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.
22. For the following:
    a. Custodial care, convalescent care or rest cures.
    b. Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
    c. Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution
    d. Services or care provided or billed by a school, custodial care center for the developmentally disabled, residential programs for drug and alcohol, or outward bound programs, even if psychotherapy is included.
    e. Wilderness camps.
23. For routine foot care (including the cutting or removal of corns and calluses); Nail trimming, cutting or debriding; Hygienic and preventive maintenance foot care, including:
    a. cleaning and soaking the feet.
    b. applying skin creams in order to maintain skin tone
    c. other services that are performed when there is not a localized illness, injury or symptom involving the foot.
24. For surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.
25. For dental treatment, regardless of origin or cause, except as specified elsewhere in this contract. "Dental treatment" includes: Preventive care, diagnosis, treatment of or related to the teeth, jawbones (except that TMJ is a covered service) or gums, including:
    a. extraction, restoration and replacement of teeth
    b. medical or surgical treatments of dental conditions.
    c. services to improve dental clinical outcomes.
26. For treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a covered service.
27. For dental implants.

28. For dental braces.
29. For dental x rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as specified elsewhere in this contract. The only exceptions to this are for any of the following:
    a. transplant preparation.
    b. initiation of immunosuppresives.
    c. direct treatment of acute traumatic injury, cancer or cleft palate.
30. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly.
31. Weight loss programs and drugs, whether or not they are pursued under medical or physician supervision. This exclusion includes commercial weight-loss programs and fasting programs.
32. For bariatric surgery, regardless of the purpose for which it is proposed or performed. This includes Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that results in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by us, are not covered. This exclusion applies when the bariatric surgery was not a covered service under this KYHC Plan or any previous KYHC plan, and it applies if the surgery was performed while the Member was covered by a previous carrier/self-funded plan prior to coverage under this contract. Directly related means that the inpatient stay or extended inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including: myocardial infarction; excessive nausea/vomiting; pneumonia; and exacerbation of co-morbid medical conditions during the procedure or in the immediate post-operative time frame.
33. For marital counseling.
34. For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a covered service. This exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery, or for soft contact lenses due to a medical condition.
35. For hearing aids or examinations to prescribe/fit them, unless otherwise specified within this contract.
36. For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.
37. For services to reverse voluntarily induced sterility.
38. For diagnostic testing or treatment related to infertility.
39. For personal hygiene, environmental control, or convenience items including the following examples:
    a. Air conditioners, humidifiers, air purifiers;
    b. Personal comfort and convenience items during an inpatient stay, including daily television rental, telephone services, cots or visitor's meals;
    c. Charges for non-medical self-care except as otherwise stated;
    d. Purchase or rental of supplies for common household use, such as water purifiers;
    e. Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds
    f. Infant helmets to treat positional plagiocephaly;
    g. Safety helmets for Members with neuromuscular diseases; or
    h. Sports helmets.

40. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a physician. This exclusion also applies to health spas.
41. For telephone consultations or consultations via electronic mail or internet/web site, except as authorized by us or allowed under the tele-health services benefit or elsewhere in covered services.
42. For care received in an emergency room which is not emergency care, except as specified in this contract. This includes suture removal in an emergency room.
43. For eye surgery to correct errors of refraction, such as near-sightedness which includes LASIK radial keratotomy or keratomileusis or excimer laser refractive keratectomy.
44. For self-help training and other forms of non-medical self-care, except as otherwise provided in this contract.
45. For examinations relating to research screenings.
46. For stand-by charges of a physician.
47. Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.
48. For private duty nursing services rendered in a hospital or skilled nursing facility; private duty nursing services are covered services only when provided through the home care services benefit as specifically stated in the ”Covered Services” section.
49. For manipulation therapy services rendered in the home as part of home care services.
50. Services and supplies related to sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, prescription drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related diagnostic testing.
51. For services, supplies and other care provided for elective abortions accomplished by any means, as defined by applicable law.
52. For (services or supplies related to) alternative or complementary medicine. Examples of services in this category include: acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage and massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.
53. For any services or supplies provided to a person not covered under the contract in connection with a surrogate pregnancy (including the bearing of a child by another woman for an infertile couple).
54. For surgical treatment of gynecomastia.
55. For treatment of hyperhidrosis (excessive sweating).
56. For any service for which you are responsible under the terms of this contract to pay a Copayment, Coinsurance or Deductible, and the Copayment, Coinsurance or Deductible is waived by a non-network provider.
57. Human Growth Hormone for children born small for gestational age. It is only a covered service in other situations when allowed by us through prior authorization.
58. Complications directly related to a service or treatment that is a non-covered service under this contract because it was determined by us to be Experimental/Investigational or non-Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental/Investigational or non-Medically

Necessary service and would not have taken place in the absence of the Experimental/Investigational or non-Medically Necessary service.

59. For drugs, devices, products, or supplies with over the counter equivalents, unless otherwise covered on the formulary, and any drugs, devices, products, or supplies that are therapeutically comparable to an over the counter drug, device, product, or supply.
60. Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.
61. Treatment of telangiectatic dermal veins (spider veins) by any method.
62. Reconstructive services except as specifically stated in the covered services section of this contract contract.
63. Nutritional and/or dietary supplements, except as provided in this contract. This exclusion includes those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist.
64. For non-preventive medical nutritional therapy from a non-network provider.

EXPERIMENTAL/INVESTIGATIVE SERVICES EXCLUSION

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 we determine to be Experimental/Investigative is not covered under this KYHC Plan.

We will deem any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if we determine 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 provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; 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 us. In determining whether a service is

Experimental/Investigative, we 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 us 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.

We will apply our medical policy 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.

ELIGIBILITY AND ENROLLMENT

Eligibility

Subscriber

To be eligible to enroll as a Subscriber, you must be:

- Under age 65;
- A legal resident of Kentucky;
- Not entitled to or enrolled in Medicare Parts A/B and or D:
- Not covered by any other group or individual health benefit plan; and
- Qualified under this contract on the effective date

Dependents
To be eligible for coverage to enroll as a dependent, you must be listed on the enrollment form completed by the Subscriber, meet all dependent eligibility criteria and be:

- The Subscriber's legal spouse.
- The Subscriber's Domestic Partner: (Domestic Partner or Domestic Partnership means a person of the same or opposite sex for whom all of the following are true: he or she is the Subscriber's sole domestic partner and has been for twelve (12) months or more; he or she is mentally competent; neither the Subscriber nor the domestic partner is related in any way (including by adoption or blood) that would prohibit him or her from being married under state law; he or she is not married to or separated from anyone else; and he or she is financially interdependent with the Subscriber.)

  For purposes of this contract, a domestic partner shall be treated the same as a spouse, and a domestic partner's child, adopted child, or child for whom a domestic partner has legal guardianship shall be treated the same as any other child. A domestic partner's or a domestic partner's child's coverage ends on the date of dissolution of the domestic partnership. To apply for coverage as domestic partners, both the Subscriber and the eligible domestic partner are required to complete and sign an enrollment application and must meet all criteria stated on the enrollment application. We reserve the right to make the ultimate decision in determining eligibility of the domestic partner.

- The Subscriber's or the Subscriber's spouse's children, including stepchildren, newborn and legally adopted children. The event date for an adopted child is the earlier of the date of filing the petition for adoption or date of placement for adoption. Placement for adoption means the assumption and retention of legal obligation for total and partial support for a child in anticipation of adoption of such child (included are natural children, adopted children and children who are required to be covered under a "Qualified Medical Child Support Order" as defined by any applicable state law). Children for whom the Subscriber or the Subscriber's spouse is a legal guardian. The Subscriber must submit an application within 31 days of the date legal guardianship is approved by the court.

Eligibility will be continued past the age limit only for those already enrolled unmarried dependents who cannot work to support themselves by reason of intellectual or physical disability. These dependents must be allowed as a federal tax exemption by the Subscriber or Subscriber's spouse. The dependent's disability must start before the end of the period they would become ineligible for coverage. This KYHC Plan must certify the dependent's eligibility. This KYHC Plan must be informed of the dependent's eligibility for continuation of coverage within 3l days after the dependent would normally become ineligible. You must notify us if the dependent's marital or tax exemption status changes and they are is no longer eligible for continued coverage.

This KYHC Plan may require the Subscriber to submit proof of continued eligibility for any enrolled child. Your failure to provide this information could result in termination of a child's coverage.

To obtain coverage for children, we may require that the Subscriber complete a "Dependency Affidavit" and provide us with a copy of any legal documents awarding guardianship of such child(ren) to the Subscriber. Temporary custody is not sufficient to establish eligibility under this contract.

Any foster child who is eligible for benefits provided by any governmental program or law will not be eligible for coverage under this KYHC Plan unless required by the laws of Kentucky.

Enrollees, qualified as Native Americans, under the U.S. accepted qualification system, shall have their cost share portions for benefits reduced to zero in accordance with the Patient Protection and Affordable Care Act.

Enrollment

Newborn and Adopted Child Coverage
Newborn children of the Subscriber or the Subscriber's spouse will be covered for illness or injury for an initial period of sixty (60) days from the date of birth, including five (5) days of nursery care for a well newborn. Coverage for newborns will continue beyond the sixty (60) days provided the Subscriber with other than family coverage submits through this KYHC Plan an Application Supplement Form to add the child under the Subscriber's contract. The Application Supplement Form must be submitted along with the additional Premium, if applicable, within sixty (60) days after the birth of the child. Failure to notify this KYHC Plan and pay any applicable premium during this 60-day period will result in no coverage for the newborn beyond the first 3l days.

A child will be considered adopted from the earlier of:

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

Adding a Child due to Award of Legal Custody or Guardianship
If a Subscriber or the Subscriber's spouse files an application for appointment of guardian for a child, an application to cover the child under the Subscriber's contract must be submitted to us within sixty (60) days of the date of the filing of the application for appointment of guardian. Coverage will be effective on the date the application for appointment of guardian is filed with the court.

Qualified Medical Child Support Order
If you are required by a Qualified Medical Child Support Order or court order, as defined by Kentucky, another state or federal law, to enroll your child under this contract, and the child is otherwise eligible for the coverage, We will permit your child to enroll at any time under this contract, and we will provide the benefits of this contract in accordance with the applicable requirements of such order.

A child's coverage under this provision will not extend beyond any dependent age limit listed in the *Schedule of Benefits*. Any claims payable under this contract will be paid, at our discretion, to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. We will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to us directly.

Adding Other Dependents
You may apply to add other persons who meet our definition of dependent and who meet our guidelines. You must apply on forms we furnish. Coverage will begin on the date a qualified dependent first becomes eligible if you apply to add them and we receive the application within

sixty (60) days of that date. If you apply later, coverage will begin after acceptance and on the date determined by this KYHC Plan. Any premium due must be paid before coverage will begin.

Notice of Changes
The Subscriber is responsible to notify us of any changes which will affect his or her eligibility or that of dependents for services or benefits under this contract. We must be notified of any changes as soon as possible but no later than within 31 days of the event. This includes changes in address, marriage, divorce, death, change of dependent disability or dependency status. Failure to notify us of persons no longer eligible for services will not obligate us to pay for such services. Acceptance of premium, for persons no longer eligible for services, will not obligate us to pay for such services.

This KYHC Plan must be notified when a Member becomes eligible for Medicare or if there are changes in the composition of any persons covered on this contract. All notifications must be in writing and on approved forms. Such notifications must include all information reasonably required to effect the necessary changes.

Your coverage terminates on the date you cease to be eligible for coverage. This KYHC Plan has the right to bill the Subscriber for the cost of any services provided to such person during the period such person was not eligible under the Subscriber's coverage.

Effective Date of Coverage
Coverage begins for the persons covered under this contract on the effective.

Statements and Forms
Subscribers or applicants for membership shall complete and submit to this KYHC Plan applications, forms or statements this KYHC Plan may reasonably request. Subscribers or applicants for membership represent to the best of their knowledge and belief that all information contained in such applications, questionnaires, forms, or statements submitted to this KYHC Plan is true, correct, and complete. Subscribers and applicants for membership understand that all rights to benefits under this contract are subject to the condition that all such information is true, correct and complete. Any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact by you may result in termination or loss of coverage.

Delivery of Documents
We will provide an identification card for each Member and a contract for each Subscriber.

CHANGES IN COVERAGE: TERMINATION AND REINSTATEMENT

Termination
Except as otherwise provided, your coverage may terminate in the following situations. This information provided below is general, and the actual effective date of termination may vary based on your specific circumstances; for example, in no event will coverage be provided beyond the date premium has been paid in full:

- If you terminate your coverage, termination will be effective on the last day of the billing period in which we received your notice of termination.
- If you move outside of the service area, or are not located within the service area, coverage terminates for the Member and all covered Dependents at the end of the billing period that contains the date you failed to meet any of the conditions above regarding the service area.

- A dependent's coverage will terminate at the end of the billing period in which notice was received by us that the person no longer meets the definition of dependent.
- If you permit the use of yours or any other Member's plan identification card by any other person; use another person's card; or use an invalid card to obtain services, your coverage will terminate immediately upon our written notice. Any Subscriber or dependent involved in the misuse of a plan identification card will be liable to and must reimburse us for the Maximum Allowed Amount for services received through such misuse.
- If you engage in fraudulent conduct or furnish us fraudulent or misleading material information relating to claims, then we may terminate your coverage. Termination is effective 3l days after our notice of termination is mailed. We will also terminate your dependent's coverage, effective on the date your coverage was terminated.
- If you stop being an eligible Subscriber, or do not pay the required premium, coverage terminates for you at the end of the period for which payment was made subject to any grace period.

A dependent's coverage terminates on the date that person no longer meets the definition of dependent.

IMPORTANT: Upon termination, we shall return promptly the unearned portion of any premium paid. Termination of the contract automatically terminates all your coverage as of the date of termination, whether or not a specific condition was incurred prior to the termination date. Covered services are eligible for payment only if your contract is in effect at the time such services are provided.

Removal of Members
A Subscriber may cancel the enrollment of any Member from this KYHC Plan. If this happens, no benefits will be provided for covered services provided after that Member's termination date.

Reinstatement
If your contract has been terminated for non-payment, we may decline to reinstate your coverage, or we may reinstate your coverage by accepting the premium due provided the request for reinstatement is received within the time period specified.

However, we have the right to require an application for reinstatement and issue a conditional receipt for the premium. Your contract will be reinstated only upon approval of your application. Lacking such approval and if you have not been notified in writing of our disapproval of your application for reinstatement within 45 days of the conditional receipt, your contract will be reinstated on the 45h day following the date of the conditional receipt.

The reinstated contract shall cover services resulting from an accidental injury that is sustained after the date of reinstatement and from an illness beginning more than ten (10) days after the date of reinstatement. Premium accepted in connection with a reinstatement will not be applied to a period more than sixty (60) days prior to the date of reinstatement.

If we fail to provide you with a thirty (30) day written notice of our cancellation, coverage will remain in effect at the existing premium until thirty (30) days after the notice is given or the effective date of replacement coverage obtained by the subscriber, whichever occurs first.

Certification of Prior Creditable Coverage

If your coverage is terminated, you and your covered dependents will receive a certification showing when you were covered under this KYHC Plan. You may need the document to qualify for another group health plan. You may also need the certification to buy, for yourself or your family, an individual policy. Certifications may be requested within 24 months of losing coverage.

You may also request a certification be provided to you at any other time, even if you have not lost coverage under this plan. If you have any questions, contact the customer service telephone number listed on the back of your identification card.

Renewability
This contract will stay in force from its date of issue at 12:01A.M. Eastern time until l2:01 A.M. Eastern time on the first or fifteenth day of the next month, whichever is applicable, or if earlier, on the date through which premiums have been paid. It will be renewed by paying the applicable premiums when due or within the grace period. The rates for each Subscriber are guaranteed for twelve (12) months at the rate in effect on the date of issue or date of renewal.

We may decline to renew or decide to terminate your contract in the event of fraud or intentional misrepresentation of a material fact under the terms of the coverage in applying for the contract or for any benefits under the contract, intentional and abusive noncompliance with health benefit plan provisions, enrollment in group coverage with this KYHC Plan, or its affiliates, nonpayment of premiums when due, noncompliance of material provisions, or for such other reasons as the Commissioner of the Kentucky Department of Insurance may approve. Any non-renewal will be without prejudice to claims for medical expenses incurred while the contract is in force.

No individually insured person will be required to replace an individual contract with group coverage on becoming eligible for group coverage that is not provided by an employer. In a situation where a person holding individual coverage is offered or becomes eligible for group coverage not provided by an employer, the person holding the individual coverage will have the option of remaining individually insured, as the Subscriber may decide. This will apply in any such situation that may arise through any health purchasing alliance, an association, an affiliated group, the Kentucky state employee health insurance plan, or any other entity.

In the event this KYHC Plan decides to discontinue offering a particular health benefit plan offered in the individual market, this KYHC Plan has the right to terminate such product as permitted by federal or state law, by giving written notice of termination to the current Subscribers at least ninety (90) days before the effective date of termination of the discontinued product. Provided further that upon discontinuance of a particular product in that market, this KYHC Plan shall offer to all Subscribers enrolled in that particular product the option, on a guaranteed issue basis, the right/option to purchase any other health benefit plan currently being offered by this KYHC Plan in that market.

Material Misrepresentation
If, within two (2) years after the effective date of this contract, we discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that you or your covered dependents did not disclose on your application, we may rescind this contract as of the original effective date. Additionally, if within two (2) years after adding an additional dependent (excluding newborn children of the Subscriber added within 3l days of birth), we discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that you or your covered dependent did not disclose on the application, We may

rescind coverage for the additional dependent as of his or her original effective date. Any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact by you, or others covered by this contract, may result in termination or rescission of coverage. You are responsible to pay us for the cost of previously received services based on the Maximum Allowed Amount for such services, less any Copayment/Coinsurance made or premium paid for such services. After the two (2) years following your effective date, we may rescind or terminate your coverage on the basis of any act, practice or omission that constitutes fraud.

Intentional Misrepresentation of Material Fact or Fraud: When a Member has committed any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact in certain situations, the above actions on the application may result in termination or rescission of this contract. This contract may also be terminated if you knowingly participate in or permit fraud or deception by any provider, vendor or any other person associated with this contract. Termination for any act, practice or omission that constitutes fraud or any intentional misrepresentation of material fact will be effective as of the effective date of coverage in the case of rescission. We will give you at least thirty (30) days written notice prior to rescission of this contract.

Loss of Eligibility

Coverage ends for a Member on the date he or she no longer meets the eligibility requirements. You must furnish any information requested regarding your eligibility and the eligibility of your dependents. You must immediately notify us of any change in a Member's status. Failure to give timely notification of a loss of eligibility will not obligate us to provide benefits for ineligible persons, even if we have accepted premiums or paid benefits.

Coverage for any Member ends upon:

- Enrollment in group coverage with this KYHC Plan or its affiliates'
- Change of residence from Kentucky.

Coverage for a spouse will terminate on the earlier of the following:

- The date you are legally divorced from your spouse;
- The date your coverage ends.

Coverage for a dependent child will terminate on the earliest of the following:

- The end of month in which the child reaches the dependent age limit, unless the child is totally disabled;
- Determination by us that a child over the age limit is no longer totally disabled;
- Termination of your coverage.

Your Right to Request Cancellation

You have the right to cancel this contract at any time by having a written notice delivered or mailed to us. Such cancellation will be effective on the first monthly renewal that is thirty (30) days after the date the notice is received provided the required premium has been paid in full. We may waive the requirement of thirty (30) days' notice. In this event, the prorated unearned portion of any premium paid will be promptly returned. Cancellation will not prejudice any claim for medical expenses incurred prior to the effective date of cancellation.

Upon termination by the Subscriber, any eligible dependents will be entitled to issuance of a contract on a guaranteed issue basis, with the same benefits, if they apply within thirty (30) days from the date the Subscriber's coverage terminates.

HOW TO OBTAIN COVERED SERVICES

Network Providers are the key to providing and coordinating your health care services. Benefits are provided when you obtain covered service from providers; however, the broadest benefits are provided for services obtained from a Primary Care Physician (PCP), Specialty Care Physician (SCP), or other Network providers. Services you obtain from any provider other than a PCP, SCP or another Network provider are considered a non-network service, except for emergency care, urgent care, or as an authorized service. Contact a PCP, SCP, other Network provider, or us to be sure that prior authorization/precertification has been obtained.

If a non-network provider meets our enrollment criteria and is willing to meet the terms and conditions for participation, that Provider has the right to become a Network provider for the product associated with this contract.

Network Services and Benefits

If your care is rendered by a PCP, SCP, or another Network provider benefits will be paid at the Network level. Regardless of Medical Necessity, no benefits will be provided for care that is not a covered service even if performed by a PCP, SCP, or another Network provider. All medical care must be under the direction of physicians. Our medical policy guidelines will be used to determine the Medical Necessity of the service.

We may inform you that it is not Medically Necessary for you to receive services or remain in a hospital or other facility. This decision is made upon review of your condition and treatment. You may appeal this decision. (*See the Complaint and Appeals section of this contract)*

- **Network Providers**: include Primary Care Physicians (PCP), Specialty Care Physicians (SCP), other professional providers, hospitals, and other facility providers who contract with us to perform services for you. PCPs include general practitioners, internists, family practitioners, pediatricians, obstetricians & gynecologists, geriatrician or other Network providers as allowed by this KYHC Plan. The Primary Care Physician is the physician who may provide, coordinate, and arrange your health care services. SCP's are Network physician who provide specialty medical services not normally provided by a PCP.

We will provide you with access to a consultation with a Network provider for a second opinion. Obtaining the second opinion shall not cost you more than your normal Copayment or Coinsurance. The Copayment or Coinsurance you are required to pay if you receive covered services under this KYHC Plan from a chiropractor, osteopath, podiatrist, licensed clinical social worker or an optometrist will be no greater than the Copayment or Coinsurance you are required to pay if the services were received from your PCP for the same or similar diagnosed condition, even if a different name or term is used to describe the condition or complaint.

For services rendered by Network providers:

1. You will not be required to file any claims for services you obtain directly from Network providers. Network providers will seek compensation for covered services rendered from us and not from you except for approved Coinsurance, Copayments and/or Deductibles. You may be billed by your Network provider(s) for any non-

covered services you receive or when you have not acted in accordance with this contract.
2. Health care management is the responsibility of the Network provider.
3. If there is no Network provider who is qualified to perform the treatment you require, contact us prior to receiving the service or treatment and we may approve a non-network provider for that service as an authorized service.

Non-Network Services
Services which are not obtained from a PCP, SCP, or another Network provider or not an authorized service will be considered a non-network service. The only exception is emergency care and urgent care. In addition, certain services are not covered unless obtained from a Network provider; see your *Schedule of Benefits*.

For services rendered by a non-network provider, you are responsible for:
1. The difference between the actual charge and the Maximum Allowable Amount plus any Deductible and/or Coinsurance/Copayments;
2. Services that are not Medically Necessary;
3. Non-covered services;
4. Filing claims; and
5. Higher cost sharing amounts.

Relationship of Parties (Plan - Network Providers)
The relationship between this KYHC Plan and Network providers is an independent contractor relationship. Network providers are not agents or employees of this KYHC Plan, nor are this KYHC Plan, or any employee of this KYHC Plan, an employee or agent of Network providers.

This KYHC Plan shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by a Member while receiving care from any Network provider or in any Network provider's facilities.

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 this KYHC Plan.

Not Liable for Provider Acts or Omissions
This KYHC Plan is not responsible for the actual care you receive from any person. This contract does not give anyone any claim, right, or cause of action against this KYHC Plan based on the actions of a provider of health care, services or supplies.

Identification Card
When you receive care, you must show your identification card. Only a Member who has paid the premiums under this contract has the right to services or benefits under this contract. If anyone receives services or benefits to which he/she is not entitled to under the terms of this contract, he/she is responsible for the actual cost of the services or benefits.

Special Circumstances
When a Member has a disability, a congenital condition, a life-threatening illness, or is past the fourth month of pregnancy, where disruption of the Member's continuity of care could cause medical harm, the treating provider may request, with the permission of the Member, that the

Member be permitted to continue treatment under the provider's care even when the provider is no longer participating with us. Approval must be obtained from us to continue such care.

CLAIMS PAYMENT

How to Obtain Benefits

When you receive care through a Network provider, you are not required to file a claim. This means that the provisions below, regarding Claim Forms and Notice of Claim, do not apply unless the provider did not file the claim. A claim must be filed for you to receive non-network services benefits, but many non-network hospitals, physicians and other providers will still submit your claim for you. If you submit the claim, use a claim form.

How Benefits Are Paid

Maximum Allowed Amount

This section describes how we determine the amount of reimbursement for covered services. Reimbursement for services rendered by Network and non-network providers is based on your contract's Maximum Allowed Amount for the covered service that you receive.

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

- that meet our definition of covered services, to the extent such services and supplies are covered under your contract 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 contract.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible nor have a Copayment or Coinsurance. In addition, when you receive covered services from a non-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 provider, we will, to the extent applicable, apply claim processing rules to the claim submitted for those covered services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect our determination of the Maximum Allowed Amount. Our application of these rules does not mean that the covered services you received were not Medically Necessary. It means we have determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same physician or other healthcare professional, we 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 a non-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 us. For covered services performed by a Network provider, the Maximum Allowed Amount for this/your contract is the rate the provider has agreed with us 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.mykyhc.org.

Providers who have not signed any contract with us and are not in any of our networks are non-network providers.

For covered services you receive from a non-network provider, the Maximum Allowed Amount for this contract will be one of the following as determined by us:

1. An amount based on our non-network provider fee schedule/rate, which we have established in our discretion, and which we reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar providers contracted with us, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or
2. An amount based on the level and/or method of reimbursement used by the Centers for Medicare and Medicaid Services for the same services or supplies; or
3. An amount based on information provided by a third party vendor, which may reflect one or more of the following factors:
    a. the complexity or severity of treatment;
    b. level of skill and experience required for the treatment; or
    c. comparable providers' fees and costs to deliver care, or
4. An amount negotiated by us or a third party vendor which has been agreed to by the provider. This may include rates for services coordinated through case management, or;
5. An amount equal to the total charges billed by the provider, but only if such charges are less than the Maximum Allowed Amount calculated by using one of the methods shown above.

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

Unlike Network providers, non-network providers may send you a bill and collect for the amount of the provider's charge that exceeds our 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 our website at www.mykyhc.org.

Customer service is also available to assist you in determining this/your contract's Maximum Allowed Amount for a particular service from a non-network provider. In order for us to assist you, you will need to obtain from your provider the specific procedure code(s) and diagnosis code(s) for the services the provider will render. You will also need to know the provider's charges to calculate your out of pocket responsibility. Although 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 non-network provider. Specifically, you may be required to pay higher cost sharing amounts or may have limits on your benefits when using non-network providers. Please see the *Schedule of Benefits* in this contract for your cost share responsibilities and limitations, or call customer service to learn how this contract's benefits or cost share amounts may vary by the type of provider you use.

We 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 non-network provider. Both services specifically excluded by the terms of your KYHC Plan and those received after benefits have been exhausted are non-covered services. 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 a non-network provider. For example, if you go to a Network hospital or provider facility and receive covered services from a non-network provider such as a radiologist, pathologist or anesthesiologist 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 non-network provider's charge.

Authorized Services
In some circumstances, such as where there is no Network provider available for the covered service, we may authorize the Network cost share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a covered service you receive from a non-network provider. In such circumstance, you must contact us in advance of obtaining the covered service. We also may authorize the Network cost share amounts to apply to a claim for covered services if you receive emergency services from a non-network provider and are not able to contact us until after the covered service is rendered. If we authorize a covered service so that you are responsible for the Network cost share amounts, you may still be liable for the difference between the Maximum Allowed Amount and the non-network provider's charge. Please contact customer service for authorized services information or to request authorization.

Payment of Benefits

Claims will be paid within thirty (30) calendar days from the date that the claim is received by us. KYHC will pay the required interest, set by the Commonwealth of Kentucky, for any payments deemed "late". You authorize us to make payments directly to providers for covered services. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims sent to, an alternate recipient (any child of a Subscriber who is recognized, under a Qualified Medical Child Support Order (QMSCO), as having a right to enrollment under the Group's contract), or that person's custodial parent or designated representative. Any payments made by us will discharge our 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 state law.

Once a provider performs a covered service, we will not honor a request for us to withhold payment of the claims submitted.

Services Performed During Same Session
We may combine the reimbursement of covered services when more than one service is performed during the same session. Reimbursement is limited to our Maximum Allowable Amount. If services are performed by non-network providers, then you are responsible for any amounts charged in excess of our Maximum Allowable Amount with or without a referral or regardless if allowed as an authorized service. Contact us for more information.

Assignment
Members cannot legally transfer the coverage. Benefits available under this contract are not assignable by any Member without obtaining written permission from this KYHC Plan, unless in a way described in this contract.

If prescription drugs are provided by a licensed pharmacist, we will recognize a valid assignment by you to the pharmacist of your right to receive payment for the prescription drugs subject to the following conditions:

- The claim must provide all of the information specified above, and;
- our payments must not have been made to you prior to our receipt of the assignment.

Payment Owed to You at Death
Any benefits owed at your death will be paid to your estate. If there is no estate, we may pay such benefits to a relative (by blood or by marriage) who appears to be equitably entitled to payment when a claim is paid, any premium due may be deducted from the claim payment.

Notice of Claim
We are not liable under this contract unless we receive written notice that covered services have been given to you. An expense is considered incurred on the date the service or supply was given.

The notice must be given to us within ninety (90) days of receiving the covered services and must have the data we need to determine benefits. If the notice submitted does not include sufficient data we need to process the claim, then the necessary data must be submitted to us within the time frames specified in this provision, or no benefits will be payable.

If we have not received the information we need to process a claim, we will ask for the additional information necessary to complete the claim. In those cases, we cannot complete the processing of the claim until the additional information requested has been received. We will make our request for additional information within thirty (30) days of our initial receipt of the

claim and will complete our processing of the claim within fifteen (15) days after our receipt of all requested information.

Failure to give us notice within ninety (90) days will not reduce any benefit if you show that the notice was given as soon as reasonably possible. As to proof of loss, no notice of an initial claim or additional information on a claim can be submitted later than one year after the usual ninety (90) day filing period ends, and no request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

Note: You have the right to obtain an itemized copy of your billed charges from the hospital or facility that provided services.

Claim Forms
Claim forms will usually be available from most providers. If forms are not available, either send a written request for claim forms to us, or contact customer service and ask for claim forms to be sent to you. Claim form(s) shall be delivered to the member within fifteen (15) days from the request. If you do not receive the claim forms, written notice of services rendered may be submitted to us without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

- Name of patient.
- Written proof covering the occurrence
- Character and extent of the loss for which the claim is made

Also, KYHC would appreciate the following information to also be supplied:

- Date, type and place of service
- Specific identification number
- Your signature and the provider's signature.

Member's Cooperation
Each Member shall complete and submit to this KYHC Plan such authorizations, consents, releases, assignments and other documents as may be requested by this KYHC Plan in order to obtain or assure reimbursement under Workers' Compensation or any other governmental program.

Time of Payment of Claims
Claims will be paid within thirty (30) calendar days from the date that the claim is received by us.

Explanation of Benefits (EOB)
After you receive medical care, you will 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 from us 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).
- General information about your appeals rights and information regarding the right to bring action after the appeals process.

Out-of-Area Services
KYHC may develop a variety of relationships with other providers. Whenever you obtain healthcare services outside of KYHC's service area, the claims for these services may be

processed by the out of area provider, which may include negotiated arrangements available between KYHC and other provider entities. In some instances, you may obtain care from nonparticipating healthcare providers, such as non-emergency care when you travel outside the U.S.

HEALTH CARE MANAGEMENT

Health care management includes the processes of precertification/prior authorization, predetermination and medical review. Its purpose is to promote the delivery of cost-effective medical care to all Members by reviewing the use of appropriate procedures, setting (place of service), and resources and optimizing the health of the Members we serve. These processes are described in the following section.

Your KYHC Plan includes the processes of precertification/prior authorization, concurrent and retrospective reviews to determine when services should be covered by your KYHC 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 KYHC Plan requires that covered services be Medically Necessary for benefits to be provided.

If you have any questions regarding the information contained in this section, you may call the customer service number on the back of your Identification Card or visit www.mykyhc.org.

Types of Requests:

- **Precertification/ Prior Authorization** – 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 us within 24 hours of 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 request for a benefit coverage determination for a service or treatment. We will review your contract 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 contract or is experimental/investigative as that term is defined in this contract.

- **Medical 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/prior authorization and did not have a predetermination review performed. Medical reviews occur for a service, treatment or admission in which we have a related clinical coverage guideline and are typically initiated by us.

Most Network providers know which services require precertification/prior authorization and will obtain any required precertification/prior authorization or request a predetermination if they feel it is necessary. Your primary care physician and other Network providers have been provided detailed information regarding health care management procedures and are responsible for

assuring that the requirements of health care management are met. The ordering provider, facility or attending physician will contact us to request a precertification/prior authorization or predetermination review ("requesting provider"). We will work directly with the requesting provider for the precertification/prior authorization request. However, you may designate an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

We will utilize our clinical coverage guidelines, such as medical policy and other internally developed clinical guidelines, and preventive care clinical coverage guidelines, to assist in making our Medical Necessity decisions. These guidelines reflect the standards of practice and medical interventions identified as appropriate medical practice. We reserve the right to review and update these clinical coverage guidelines periodically. Your contract 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 precertification/prior authorization telephone number on the back of your identification card.

Request Categories:

- **Urgent**: a request for precertification/prior authorization 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/prior authorization or predetermination that is conducted prior to the service, treatment or admission.
- **Concurrent**: a request for precertification/prior authorization or predetermination that is conducted during the course of treatment or admission.
- **Retrospective**: a request for precertification/prior authorization that is conducted after the service, treatment or admission has occurred. Medical reviews are 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 on state and federal regulations. Where Kentucky regulations are stricter than federal regulations, we will abide by Kentucky regulations. If you receive services in a state other than Kentucky, where your contract was issued, other sections of this contract will apply. You may call the telephone number on the back of your membership card for additional information.

Request Category	**Timeframe Requirement for Decision and Notification**
Prospective Urgent	2 business days from the receipt of request/notify provider within 24 hours of any decision/notify all within 1 business day for adverse determination.

Prospective Non-Urgent	2 business days from the receipt of request/notify provider within 24 hours of any decision/notify all within 1 business day for adverse determination request
Concurrent Urgent	24 hours from request and prior to expiration of current certification/ notify all within 1 business day for adverse determination
Other Concurrent Urgent when request is received > 24 hours before the expiration of the previous authorization	24 hours from receipt of the request/notify all within 1 business day for adverse determination
Concurrent Urgent when request is received less than 24 hours before the expiration of the previous authorization or no previous authorization exists	24 hours from receipt of the request or 1 business day from receipt of request, whichever is less/ notify all within 1 business day for adverse determination
Concurrent Non-Urgent	1 business day from receipt of the/ notify all within 1business day for adverse determination
Post-Service	10 calendar days from receipt of the request

PREDETERMINATION

Request Category	**Timeframe Requirement for Decision and Notification**
Prospective Urgent	72 hours from the receipt of request
Prospective Non-Urgent	15 calendar days from the receipt of the request
Concurrent when hospitalized at time of request expiration of current certification	24 hours from request and prior to
Other Concurrent Urgent when request is received > 24 hours before the expiration of the previous authorization	24 hours from receipt of the request
Concurrent Urgent when request is received less than 24 hours before the expiration of the previous authorization or no previous authorization exists	24 hours from receipt of the request
Concurrent Non-Urgent	15 calendar days from receipt of the request

Post-Service	30 calendar days from receipt of the request

If additional information is needed to make our decision, we 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 we do 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 our possession.

We will provide notification of our decision in accordance with state and federal regulations. Notification may be given by the following methods:

- **Verba**l: 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/Prior Authorization 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. premium must be paid for the time period that services are rendered;
3. the service or surgery must be a covered benefit under your contract;
4. the service cannot be subject to an exclusion under your contract, including a pre-existing condition limitation or exclusion; and
5. you must not have exceeded any applicable limits under your contract

CARE MANAGEMENT

Care management is a health care management feature designed to help promote the timely coordination of services for Members with health-care related needs due to serious, complex, and/or chronic medical conditions. Our care management programs coordinate health care benefits and available services to help meet health-related needs of Members who are invited and agree to participate in the care management program.

Our care management programs are confidential and voluntary. These programs are provided at no additional cost to you and do not affect covered services in any way. Licensed health care professionals trained in care management and familiar with the benefit plan provide these services.

For Members who meet program requirements/criteria and who agree to participate in a care management program, a licensed health care professional completes an assessment and develops an individualized plan designed to help meet their identified health care related needs. This is achieved through communication, and collaboration with the Member and/or Member's designated representative, treating physician(s), and other providers. The licensed health care professional remains in contact with the Member by telephone on a periodic basis to help accomplish the goals of the plan.

In addition to coordinating benefits, the licensed health care professional may assist with coordination of care with existing community-based programs and services to meet the Member's needs. Care coordination may include referrals to external agencies and available community-based programs and services.

Voluntary Wellness Incentive Programs
We may offer health or fitness related program options for purchase by you. If you have selected this option, you may receive incentives such as gift cards by participating in or completing such voluntary wellness promotion programs as health assessments, weight management or tobacco cessation coaching. (Use of gift cards for purposes other than for qualified medical expenses may result in taxable income to you. For additional guidance, please consult your tax advisor.) These programs are not covered services under your plan but are a value added component of your plan benefits. These program features are not guaranteed under your contract and could be discontinued at any time.

Value-Added Programs
We may offer health or fitness related programs to you, 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 this KYHC Plan but are in addition to plan benefits. As such, program features are not guaranteed under your contract and could be discontinued at any time. We do not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.

COMPLAINT AND APPEALS PROCEDURES

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.

Our customer service representatives are specially trained to answer your questions about our health benefit plans. Please call during business hours, Monday through Friday, with questions regarding:

- Your coverage and benefit levels, including Copayment amounts;
- Specific claims or services you have received;
- Doctors or hospitals in the Network;
- Authorizations; and/or
- Provider directories.

You will be notified, in writing, if a claim or other request for benefits is denied in whole or in part. If such a request is denied, the notice of denial will explain why benefits were denied and describe your rights under the appeals procedure. A complaint procedure also exists to help you understand this KYHC Plan's determinations.

The Complaint Procedure
A complaint procedure is available to provide reasonable, informative responses to complaints that you may have concerning this KYHC Plan. A complaint is an expression of dissatisfaction

that can often be resolved by an explanation from this KYHC Plan of its procedures and contracts. A written complaint is considered to be a grievance under Kentucky law. This KYHC Plan invites you to share any concerns that you may have over benefit determinations, coverage cancellations, or the quality of care rendered by medical providers in this KYHC Plan's Networks.

If you have a complaint or problem concerning benefits or services, please contact us. Please refer to your identification card for our address and telephone number. You may submit your complaint by letter or by telephone call. Or, if you wish, you may meet with your local service representative to discuss your complaint. Members are encouraged to file complaints within sixty (60) days of an initial, adverse action, but must file within six (6) months after receipt of notice of the initial, adverse action. The time required to review complaints does not extend the time in which appeals must be filed.

The Appeals Procedure

An appeal is a formal request from you for this KYHC Plan to change a previous determination. If you are notified in writing of any adverse determination or coverage denial, you will be advised of your right to an internal appeal and an external review if appropriate. You also have a right to appeal if we fail to make a utilization review determination and provide written notice within the required time frame. For purposes of this section:

- Coverage denial means our determination that a service, treatment, drug or device is specifically limited or excluded under this contract.
- Adverse determination means our denial, reduction, or termination of a benefit (either in whole or in part) based on any of the following:
    - A determination that the Member is not eligible to participate in the plan, including the denial, reduction, or termination of a benefit (in whole or in part) as a result of a utilization review;
    - A determination that the benefit is Experimental / Investigative or not Medically Necessary;
    - A determination that the benefit is not a covered benefit under this KYHC plan; or

Adverse determination includes any rescission of coverage, whether or not, in connection with the rescission, there is an adverse effect on any particular benefit.

The internal appeals process may be initiated by the Member, the Member's authorized representative, or a provider acting on behalf of the Member within sixty (60) days of receipt of our written notice of an adverse determination, a coverage denial or any other adverse decision made by us, but must be filed within six (6) months of your receipt of the initial decision. The request should include any medical information pertinent to the appeal. All portions of the medical records that are relevant to the appeal and any other comments, documents, records or other information submitted by the Member relating to the issue being appealed, regardless of whether such information was considered in making the initial decision, will be considered in the review of the appeal. Any new medical information pertinent to the appeal will also be considered. Members are entitled to receive, upon request and free of charge, reasonable access to, and copies of, documents, records, and other information relevant to the Member's appeal.

In addition, we will also provide the Member, free of charge, with any new or additional evidence we will consider, rely upon, or generate in connection with the claim, as well as our rationale for making any adverse determination. We will provide this as soon as possible and sufficiently in

advance of the date on which the final adverse determination is due, by law, to give the Member a reasonable opportunity to respond prior to that date.

The Member will continue coverage under the contract pending the outcome of the internal appeal, as long as the Member remains eligible for coverage. If the Member has undertaken an ongoing course of treatment, it may only be reduced or terminated by advance notice.

If a representative is seeking an appeal on behalf of a Member, we must obtain a signed Designation of Representation (DOR) form from the Member. The appeal process will not begin until KYHC has received the properly completed DOR form except that if a physician requests an expedited internal appeal on behalf of a Member, the physician will be deemed to be the Member's representative for the purpose of filing the expedited internal appeal without receipt of a signed form. We will forward a Designation of Representation form to the Member for completion in all other situations.

We will ensure that appeals are reviewed in a manner designed to ensure the independence and partiality of the individuals responsible for reviewing your request for an internal appeal (referred to as qualified reviewers). The qualified reviewers will not be the same individuals who made the initial denial or determination. They will not be the subordinates of the initial decision maker either and no deference will be given to the initial decision. If the internal appeal is related to an adverse determination or any other adverse decision that is based in whole or in part on a medical judgment, at least one individual conducting the appeal will be a licensed physician (or if the determination involves services rendered by a chiropractor or optometrist, a chiropractor or optometrist licensed in Kentucky) unless a nurse can approve the request. If the appeal is related to a medical or surgical specialty or subspecialty, upon request by the Member, their authorized representative, or the Member's provider, at least one (1) individual conducting the appeal will be a board eligible or certified physician in the appropriate specialty or subspecialty.

Within a reasonable time given the medical circumstances and no later than thirty (30) days after receiving a written or an oral request for appeal, we will send a written decision to the Member or their authorized representative and, if applicable, the Member's provider. If we fail to resolve the appeal with the required timeframe, the Member may pursue external review as described later in this section. This option is not available, however, if our failure to resolve the appeal is due to a de minimus violation that does not cause harm to the Member or is not likely to cause prejudice or harm to the Member, if the delay is for good cause or due to matters beyond our control, and is part of an ongoing, good faith exchange of information between the Member and us.

Expedited Appeals

An expedited appeal is deemed necessary when the Member is hospitalized, or in the opinion of the treating provider (or any physician with knowledge of the Member's medical condition), review under the standard time frame could, in the absence of immediate medical attention, result in any of the following:

- Placing the health of the Member or, with respect to a pregnant woman, the health of the Member or the unborn child in serious jeopardy;
- Subjecting the Member to severe pain that cannot be adequately managed;
- Serious impairment to bodily functions;
- Serious dysfunction of a bodily organ or part; or

- Any claim that a physician with knowledge of the Member's medical condition determines is a claim involving urgent care.

In addition, Members in urgent care situations and Members receiving an ongoing course of treatment may be allowed to proceed with an expedited external review at the same time as the internal appeals process.

This KYHC Plan, applying a prudent lay-person standard, may also determine that an appeal may be expedited. The request for an expedited internal appeal may be in writing or an oral request, followed up by an abbreviated written request by a Member, the Member's authorized representative or provider acting on behalf of the Member. We have the right to require verification from the treating provider (or other physician with knowledge of the Member's medical condition), that the Member's condition warrants an expedited internal appeal. The process for the expedited internal appeal is similar to the standard internal appeal, except that We will communicate our decision to the Member or their authorized representative as soon as possible taking into account the medical urgency of the situation, but no later than 72 hours after receipt of the request for an expedited internal appeal. All necessary information, including our decision on review, shall be transmitted between us and the Member or their authorized representative by telephone, facsimile, or other available similarly expeditious method.

If our decision is to uphold a coverage denial, the Member, the Member's authorized representative or a provider acting on behalf of and with the consent of the Member may contact the Kentucky Department of Insurance, Health and Life Division, 215 W. Main Street, P.O. Box 517, Frankfort, KY 40602, and request a review of our decision. The department will make a determination as to whether the service should or should not be covered. If the department determines the disputed service should be covered, it may direct us to either pay the service or offer external review to resolve the issue.

External Review by an Independent Review Entity
The Member, the Member's authorized representative, or a provider acting on behalf of and with the consent of the Member may request an external review of an adverse determination if the following criteria are met:

- The internal appeal process outlined above was completed or jointly waived by you and us or we failed to make a determination within thirty (30) days of receiving the written appeal or within 72 hours of receiving the request for an expedited appeal; and
- The Member was covered under this contract on the date of service or, if a prospective denial, the Member was eligible to receive benefits under this contract on the date the proposed service was requested.

The request for an external review of an adverse determination must be sent to us within four (4) months of receiving our written decision rendered under the internal appeals process. As part of the request, the Member shall provide written consent authorizing the independent review entity to obtain all medical records from us and any provider utilized for review purposes regarding the decision to deny, limit, reduce or terminate coverage.

We will determine if the Member's request qualifies for independent review and will refer all eligible requests to the Kentucky Department of Insurance, who will assign an independent review entity. Independent review entities are assigned on a rotating basis so that we do not have the same independent review entity for two consecutive external reviews. We will inform the Member in writing of the independent review entity that will be conducting the review and inform the Member of their right to submit additional information to the independent review entity

within five (5) days. If the independent review entity receives the information within five (5) days they will include it in their review and forward a copy to us within one (1) day. We will also forward all information required to be considered for an external review to the independent review entity within three (3) business days of assignment.

The Member will be assessed a filing fee of $25 to be paid to the independent review entity. This fee may be waived if the independent review entity determines that the fee creates a financial hardship on the Member. The fee shall be refunded if the independent review entity finds in favor of the Member. If the Member submits multiple requests for external review within a one-year period, the Member will not have to pay more than $75 per year in filing fees. We will be responsible for the rest of the cost of the external review. The independent review entity will send a written decision to the Member within 21 days from receipt of all information required from us. An extension of up to fourteen (14) days may be allowed if agreed to by the Member and us. In no event will the independent review entity take longer than 45 days to complete their review.

The Member will not be afforded an external review of an adverse determination if:

- The subject of the Member's adverse determination has previously gone through the external review process and the independent review entity found in favor of us; and
- No relevant new clinical information has been submitted to us since the independent review entity found in favor of us.

If a dispute arises between us and the Member regarding the right to an external review, the Member may file a complaint with the Kentucky Department of Insurance. Within five (5) days of receipt of the complaint, the department shall render a decision and may direct us to submit the dispute to an independent review entity for an external review if it finds that the dispute involves denial of coverage based on Medical Necessity or the service being Experimental/Investigative and all other external review requirements have been met.

Expedited External Reviews

External reviews shall be conducted in an expedited manner by the independent review entity if the Member is hospitalized, or if, in the opinion of the treating provider, review under the standard time frame could, in the absence of immediate medical attention, result in any of the following:

- Placing the health of the Member or, with respect to a pregnant woman, the health of the Member or her unborn child in serious jeopardy;
- Subjecting the Member to severe pain that cannot be adequately managed;
- Serious impairment to bodily functions; or
- Serious dysfunction of a bodily organ or part.

Expedited reviews are also available if the Member is requesting review of a decision that a recommended or requested service is Experimental/Investigative and the Member's physician certifies in writing that the requested service would be significantly less effective if not promptly initiated.

Members may pursue an expedited external review while simultaneously pursuing an expedited internal appeal. The request for an expedited external review may be in writing or an oral request, followed up by an abbreviated written request, by a Member, the Member's authorized representative or provider acting on behalf of and with the consent of the Member. Requests for expedited external review shall be forwarded by us to the independent review entity within 24

hours of receipt. We will call the independent review entity to confirm that a specialist is available and that the review has been accepted.

For expedited external review, a determination shall be made by the independent review entity within 24 hours from receipt of all information required from us. An extension of up to 24 hours may be allowed if agreed to by the Member and us. We will provide notice to the independent review entity and to the Member by same day communication that the adverse determination has been assigned to an independent review entity for expedited review. In no event will the independent review entity take longer than 72 hours to complete their review.

The Decision of the Independent Review Entity
The independent review entity shall provide to the Member, treating provider, the Kentucky Department of Insurance and us a decision which shall include:

- The findings for either us or the Member regarding each issue under review;
- The proposed service, treatment, drug, device or supply for which the review was performed;
- The relevant provisions in the contract and how applied; and
- The relevant provisions of any nationally recognized and peer-reviewed medical or scientific documents used in the external review.

Records provided to independent review organizations are handled as confidential records.

The decision of the independent review entity will be binding on us and the Member except to the extent that there are remedies available under applicable state or federal law.

Contact Person For Appeals
The request for an internal appeal or an external review and supporting documentation must be submitted to the following address or telephone number or to the appeal address or telephone number provided on your written notice of an adverse decision:

Position: Appeals Coordinator
Address: 9700 Ormsby Station Rd. Suite 100 Louisville, KY. 40233
Phone: 1-855-OUR-KYHC (687-5942)
TTY: 1-800-648-6056
Fax: 1-866-612-7862

The person holding the position named above will be responsible for processing your request. This KYHC Plan encourages its Members to submit requests for appeal in writing. The request for appeal should describe the problem in detail. Attach copies of bills, medical records, or other appropriate documentation to support the appeal that may be in your possession.

You must file appeals on a timely basis. You are encouraged to file internal appeals within sixty (60) days of your receipt of this KYHC Plan's initial decision. Internal appeals must be filed, however, within six (6) months of your receipt of the initial decision. If the right to external review exists as described above, the external review request must be filed with this KYHC Plan within four (4) months of your receipt of the final, internal appeal decision.

Kentucky Health Insurance Advocate
In addition to contacting us, you can also contact the Kentucky Health Insurance Advocate at the Kentucky Department of Insurance for assistance with the claims and appeals and external review processes described above. You can contact the Insurance Advocate by email at DOI.CAPombudsman@ky.gov or you can call 877-587-7222.

Medical Services
We are not liable for the furnishing of covered services, but merely for the payment of them. You shall have no claim against us for acts or omissions of any provider from whom you receive covered services. We have no responsibility for a provider's failure or refusal to give covered services to you.

Limitation of Actions
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 no earlier than sixty (60) days after we receive the claim or other request for benefits and within three (3) years of KYHC's final decision on the claim or other request for benefits. If this KYHC Plan decides an appeal is untimely, the latest decision on the merits of the underlying claim or benefit request is the final decision date.

You must exhaust this KYHC Plan's internal appeals procedure before filing a lawsuit or other legal action of any kind against this KYHC Plan.

GENERAL PROVISIONS

Entire Contract
This contract, the application, any riders, endorsements or amendments, constitute the entire contract between this KYHC Plan and you and, as of the effective date, supersede all other agreements between the parties. Any and all statements made to this KYHC Plan by you and any and all statements made to you by this KYHC Plan are representations and not warranties, and no such statement, unless it is contained in a written application for coverage under this contract, shall be used in defense to a claim under this contract.

Note: the laws of the Commonwealth of Kentucky will apply unless otherwise stated herein.

Form or Content of Contract
No agent or employee of this KYHC Plan is authorized to change the form or content of this contract. Changes can only be made through a written authorization, signed by an officer of this KYHC Plan.

Time Limit on Certain Defenses
After three (3) years from the date of issue of this contract, or the date of its last reinstatement, if any, no misstatements, except fraudulent misstatements, made by you in the application for the contract will be used to void or cancel the contract or to deny a claim.

Contract Modifications
This KYHC Plan reserves the right to change the benefit provision effective on your renewal date, and the terms and conditions thereof, provided for under this contract by giving written notice to the Subscriber not less than thirty (30) days prior to the effective date of such change; however, such notice requirement shall not apply to changes in benefits provisions that are required by state or federal law.

Premium
You shall have the responsibility for remitting payments to KYHC as they come due. Even if you have not received a premium bill from KYHC, you are still obligated to pay, at a minimum, the amount of the prior premium bill.

In the event that there are insufficient funds in your account to cover the amount of your premium payment at the time your payment is presented to your financial institution, a fee may appear on a subsequent premium notice to satisfy the fee charged for insufficient funds.

The Member's monthly premium for this contract is provided to the member upon enrollment. The contract between us and the Subscriber includes this contract, your *Schedule of Benefits*, your application, any supplemental application or change form, your identification card, and any endorsements or riders. Please also keep any communications you receive from KYHC as part of your overall documentation.

The amount of premium is also printed on your premium notice; however, this amount is subject to change as allowed by law. We will not increase premium for any reason without giving you at least thirty (30) days written notice. We will then send you a new notice with the new premium amount.

If a premium increase is necessary, we will bill you for the extra amount due. If this amount is not paid, this contract will be canceled at the end of the grace period and you will receive a refund of any unearned premium.

If a decrease in premium is appropriate, we will adjust what is owed to us and let you know the new amount of premium due. We will refund any excess premium to you.

If we have not charged the proper amount of premium, we will let you know the new amount of premium due from you. We will refund any amount which has been overpaid to us. You must pay us any amounts which should have been paid but were not.

If premium has been paid for any period of time after this contract has been canceled, we will refund that premium to you. The refund will be for that period of time after your coverage ends. Also, if a Member dies while this contract is in force, we will refund the premium paid for such Member for any period after the date of the Member's death to you or your estate.

Grace Period
The contract has a standard 30-day Grace Period with a 90-day Grace period for those who receive premium tax credits from the U.S. government. This means if any premium except the first is not paid by its payment due date, it may be paid during the next 30 or 90 days, as applicable. During the 30-day or 90-day respective grace period, the contract shall continue in force. However, while claims will be processed by KYHC during the first 31 days of this grace period, any claims incurred and submitted during the remaining 60 days of the grace period will be pended until premium is received. If premium is not received within the grace period, these pended claims will be denied, and this contract will automatically terminate retroactively to the last day of the first month of the ninety (90) day Grace Period if premium is not paid. Upon termination of the contract as provided in this paragraph, KYHC shall only have liability to make payment for covered services through the last day of the first month of the ninety (90) day Grace Period. You may be able to reinstate this contract after it ends, as detailed in the reinstatement section.

Changes in Premiums
The rates for each Subscriber are guaranteed for twelve (12) months at the rate in effect on the date of issue or date of renewal. The premium for this contract may change subject to, and as permitted by, applicable law. You will be notified of a proposed premium change at the address in our records thirty (30) days in advance. Any such change will apply to premiums due on or after the effective date of change. If advance premiums have been paid beyond the effective date of a rate change, such premiums will be adjusted as of that effective date to comply with the rate change. Additional premiums may be billed, if necessary, for future periods.

Premium Refunds
All unearned premium, less any claims paid, will be refunded.

Entire Money
The entire money and other considerations therefor shall be expressed therein.

Disagreement with Recommended Treatment
Each member/participant enrolls in this KYHC Plan with the understanding that they, in consultation with their providers, are responsible for determining the treatment appropriate for their care. You may, for personal reasons, refuse to accept procedures or treatment recommended by your providers. Providers may regard such refusal to accept their recommendations as incompatible with continuance of the physician-patient relationship and as obstructing the provision of proper medical care. In this event, the provider shall find providers available who will render the care.

If you refuse to follow a recommended treatment or procedure, and the provider believes that no professionally acceptable alternative exists, you will be so advised. In such case, neither this KYHC Plan, nor any provider shall have any further responsibility to provide care in the case of the provider, and to arrange care in the case of this KYHC Plan for the condition under treatment or any complications thereof.

Circumstances Beyond the Control of the Plan
If circumstances arise which are beyond the control of this KYHC Plan, this KYHC Plan will make a good-faith gesture to arrange an alternative method of providing coverage. Circumstances that may occur, but are not within the control of this KYHC Plan, include but are not limited to, a major disaster or epidemic, complete or partial destruction of facilities, a riot, civil insurrection, labor disputes that are out of the control of this KYHC Plan, disability affecting a significant number of a Network provider's staff or similar causes, or health care services provided under this contract are delayed or considered impractical. Under such circumstances, this KYHC Plan and Network providers will provide the health care services covered by this contract as far as is practical under the circumstances, and according to their best judgment. However, this KYHC Plan and Network providers will accept no liability or obligation for delay, or failure to provide or arrange health care services if the failure or delay is caused by events/circumstances beyond the control of this KYHC Plan.

Medicare
Any benefits covered under both this contract and Medicare will be paid pursuant to Medicare secondary payor legislation, regulations, and Centers for Medicare & Medicaid Services (CMS) guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, contract provisions, and federal law.

Cessation of Operations
In the event of the cessation of operations or dissolution of this KYHC Plan, this contract may be terminated by us with required (180) day notices sent to impacted members and the Kentucky Commissioner of Insurance. This KYHC Plan will be obligated for services for the remainder of the period in which premiums were prepaid or as otherwise prescribed by law as outline in KRS 304.17A-245.

COORDINATION OF BENEFITS

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

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

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

Definitions

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

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

"Plan" is not any of the following:

1. School accident-type coverage for grammar, high school, and college students for accidents only, including athletic injuries, either on a 24 hour basis or on a "to and from" school basis

Primary Plan/Secondary Plan: the *Order of Benefit Determination Rules* state whether this KYHC Plan is a primary plan or secondary plan as to another plan covering the person.

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

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

When there are more than two plans covering the person, this KYHC plan may be a primary plan as to one or more other plans, and may be a secondary plan as to a different plan or plans.

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

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

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

When the benefits are reduced under a primary plan because a Member does not comply with the plan provisions, the amount of such reduction will not be considered an allowable expense. Examples of such provisions are those related to second surgical opinions, precertification/prior authorization of admissions or services, and preferred provider arrangements. Only benefit reductions based upon provisions similar to this one and which are contained in the primary plan may be excluded from allowable expenses. This provision shall not be used by a secondary plan to refuse to pay benefits because a health maintenance organization (HMO) member has elected to have health care services provided by a non-HMO provider and the HMO, pursuant to its contract, is not obligated to pay for providing those services.

Allowable expense does not include any expenses incurred or claims made under the prescription drug program of this KYHC Plan.

Claim Determination Period: means a period of at least twelve (12) consecutive months, over which allowable expenses shall be compared with total benefits payable in the absence of coordination of benefits, to determine whether over-insurance exists and how much each plan will pay or provide.

Benefit Reserve: means the savings recorded by a plan for claims paid for a Member as a secondary plan rather than as a primary plan.

Order of Benefit Determination Rules
When there is a basis for a claim under this KYHC Plan and another plan, this KYHC Plan is a secondary plan which has its benefits determined after those of the other plan, unless:

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

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

1. Non-Dependent/Dependent: The benefits of this KYHC Plan which covers the person as an employee or Subscriber (that is, other than as a dependent) are determined before those of this KYHC Plan which covers the person as a dependent.

2. Dependent Child/Parents not Separated or Divorced: Except as stated in paragraph 3. below, when this KYHC Plan and another plan cover the same child as a dependent of different parents who are not separated or divorced:
    a. The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in the year;
        i. If the parents are married;
        ii. the parents are not separated (whether or not they ever have been married); or
        iii. a court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage; but
    b. If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time.
3. Dependent Child/Separated or Divorced Parents: If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
    a. First, the plan of the parent with custody of the child;
    b. Then, the plan of the spouse of the parent with custody of the child;
    c. Then, the plan of the parent not having custody of the child; and
    d. Finally, the plan of the spouse of the non-custodial parent.

    However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the plan has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent will be the secondary plan. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's spouse does, the spouse's plan is primary. This sub-clause does not apply to any *Claim Determination Period* or plan year during which any benefits are actually paid or provided before the entity has actual knowledge.

4. Joint Custody: If the specific terms of a court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the *Order of Benefit Determination Rules* outlined above.

5. Active/Inactive Subscriber: The benefits of a plan which covers a person as an employee who is neither laid off nor retired or as that employee's Dependent are determined before those of a plan which covers that person as a laid off or retired employee or as that employee's dependent. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not supersede the Non-Dependent/Dependent rule above.

6. Continuation Coverage: If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following shall be the order of benefit determination:

    a. First, the benefits of a plan covering the person as an employee, Subscriber or Subscriber of as that person's dependent;

b. Second, the benefits under the continuation coverage. If the other plan does not have the rule described above and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

7. Longer/Shorter Length of Coverage: If none of the above rules determines the order of benefits, the benefits of the plan which covered the person longer are determined before those of the plan which covered that person for the shorter term. If none of the preceding rules determines the primary plan, the allowable expenses shall be shared equally between the plans.

Effect on this Plan's Benefits
When a Member is covered under two or more plans which together pay more than the Allowable Expense, the plan will pay this KYHC Plan's benefits according to the *Order of Benefit Determination Rules*. This contract's benefit payments will not be affected when it is primary. However, when this contract is secondary under the *Order of Benefit Determination Rules*, benefits payable will be reduced, if necessary, so that combined benefits of all plans covering you or your dependent do not exceed the allowable expense.

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

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

When the benefits of this KYHC Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this KYHC Plan. If this KYHC Plan is secondary, any benefit reserve accumulated for a Member will be used to pay allowable expenses of that Member only, not otherwise paid during the claim determination period. The benefit reserve, if any, will return to zero at the end of the claim determination period.

Right to Receive and Release Needed Information
Certain facts are needed to apply these rules. This KYHC Plan has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. This KYHC Plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under this contract must give this KYHC Plan any facts it needs to pay the claim.

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

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

1. The persons it has paid or for whom it has paid;

2. Insurance companies; or
3. Other organizations.

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

Physical Examination
When a claim is pending, we reserve the right to request a Member to be examined, or autopsied, by an applicable provider, at our expense. This will be requested as often as reasonably required.

Worker's Compensation
The benefits under this contract are not designed to duplicate any benefit for which Members are eligible under the Worker's Compensation Law. All sums paid or payable by Worker's Compensation for services provided to a Member shall be reimbursed by, or on behalf of, the Member to this KYHC Plan to the extent this KYHC 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 Worker's Compensation.

Subrogation and Reimbursement
These provisions apply when we pay benefits as a result of injuries or illness you sustained and you have a right to a recovery or have received a recovery.

Subrogation
We have the right to recover payments we make on your behalf from any party responsible for compensating you for your injuries. The following apply:

- We have first priority for the full amount of benefits we have paid from any recovery regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses and injuries.
- You and your legal representative must do whatever is necessary to enable us to exercise our rights and do nothing to prejudice them.
- We have the right to take whatever legal action we see fit against any party or entity to recover the benefits paid under this contract.
- To the extent that the total assets from which a recovery is available are insufficient to satisfy in full our subrogation claim and any claim still held by you, our subrogation claim shall be first satisfied before any part of a recovery is applied to your claim, your attorney fees, other expenses or costs.
- We are not responsible for any attorney fees, other expenses or costs you incur without our prior written consent. We further agree that 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 us.

Reimbursement
If you obtain a recovery and we have not been repaid for the benefits we paid on your behalf, we shall have a right to be repaid from the recovery in the amount of the benefits paid on your behalf and the following apply:

- You must reimburse us to the extent of benefits we paid on your behalf from any recovery.
- Notwithstanding any allocation made in a settlement agreement or court order, we shall have a right of recovery, in first priority, against any recovery.

- You and your legal representative must hold in trust for us 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 us immediately upon your receipt of the recovery. You must reimburse us, 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 us.
- If you fail to repay us, we shall be entitled to deduct any of the unsatisfied portion of the amount of benefits We have paid or the amount of your recovery whichever is less, from any future benefit under this KYHC Plan if:
    - The amount we paid on your behalf is not repaid or otherwise recovered by us; or
    - You fail to cooperate.
- In the event that you fail to disclose to us the amount of your settlement, we shall be entitled to deduct the amount of our lien from any future benefit under this KYHC Plan.
- We shall also be entitled to recover any of the unsatisfied portion of the amount we have paid or the amount of your settlement, whichever is less, directly from the providers to whom we have made payments. In such a circumstance, it may then be your obligation to pay the provider the full billed amount, and we would not have any obligation to pay the provider.
- We are 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 or make you whole.

Your Duties

- You must notify us 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 us in the investigation, settlement and protection of our rights.
- You must not do anything to prejudice our rights.
- You must send us 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 us if you retain an attorney or if a lawsuit is filed on your behalf.

Right of Recovery

Whenever payment has been made in error, we will have the right to recover such payment from the provider. In the event we recover a payment made in error from the provider, except in cases of fraud, we will only recover such payment from the provider during the 24 months after the date we made the payment on a claim submitted by the provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim.

We have oversight responsibility for compliance with provider and vendor and subcontractor contracts. We 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. We have established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise recovery amounts. We will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. We may not provide you with notice of overpayments made by us or you if the recovery method makes providing such notice administratively burdensome.

Other Government Programs
The benefits under this contract shall not duplicate any benefits that Members are entitled to, or eligible for, under any other governmental program. This does not apply if any particular laws require this KYHC Plan to be the primary payor. If this KYHC Plan has duplicated such benefits, all money paid by such programs to Members for services they have or are receiving, shall be paid by or on behalf of the Member to this KYHC Plan.

Notice
Any notice given under this contract shall be in writing. The notices shall be sent to: Kentucky Health Cooperative 9700 Ormsby Station Rd. Suite 100, Louisville, Kentucky 40223. If we are forwarding you a notice, it will be sent to your most recent address as it appears in this KYHC Plan's system records.

Conformity with Law
Any provision of this KYHC Plan which is in conflict with the laws of the Commonwealth of Kentucky, or with federal law, is hereby automatically amended to conform to the minimum requirements of such laws.

Clerical Error
A clerical error will never disturb or affect a Member's coverage, as long as the Member's coverage is valid under the rules of this contract. This rule applies to any clerical error, regardless of whether it was the fault of the Subscriber or this KYHC Plan.

Policies and Procedures
This KYHC Plan is able to introduce new policies, procedures, rules and interpretations, as long as they are reasonable. Such changes are introduced to make the contract more orderly and efficient.

Waiver
No agent or other person, except an authorized officer of this KYHC Plan, has authority to waive any conditions or restrictions of this contract, to extend the time for making a payment to this KYHC Plan, or to bind this KYHC Plan by making any promise or representation or by giving or receiving any information.

Additional Benefits
This KYHC Plan has the authority to cover services and supplies not specifically covered by the contract. This applies if this KYHC Plan 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. You have the right to change your beneficiary and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

Reservation of Discretionary Authority
This KYHC Plan, or anyone acting on our behalf, shall determine the administration of benefits and eligibility for participation in such a manner that has a rational relationship to the terms set forth herein. However, we, or anyone acting on our behalf, have, to the fullest extent permitted under applicable law, discretion to determine administration of your benefits. Our determination shall be binding, subject to any rights of complaint and/or appeal provided under the contract or under applicable law. This may include, without limitation, determinations of whether the services, care, treatment, or supplies are Medically Necessary, Experimental/Investigational, whether surgery is cosmetic, and whether charges are consistent with our Maximum Allowed

Amount. However a Member may utilize all applicable complaint and/or appeals procedures specified in the contract or otherwise required by applicable law. This reservation of discretionary authority shall not be used in such a manner as to deny coverage clearly set forth in the contract or to arbitrarily construe or abuse the provision of benefits or rights of appeal under the contract. This reservation of discretionary authority does not prohibit you from seeking judicial review of our determination after exhausting administrative remedies.

This KYHC Plan, or anyone acting on our behalf; shall have all the powers necessary or appropriate to enable us to carry out our duties in connection with the operation and administration of this contract. This includes, without limitation, the power to construe the contract, to determine all questions arising under the contract and to make, establish and amend the rules, regulations and procedures with regard to the interpretation and administration of the provisions of this contract. However, these powers shall be exercised in such a manner that has reasonable relationship to the provisions of the contract, provider agreements, and applicable state or federal laws. A specific limitation or exclusion will override more general benefit language.

Misstatement of Age
If the premium for this contract is based on your age and if your age has been misstated, the benefits will be those the premium paid would have purchased at the correct age.

Severability
In the event that any provision in this contract is declared legally invalid by a court of law or determined to be illegal due to the enactment of new legislation or regulations, such provision will be severable and all other provisions of the contract will remain in force and effect.

Headings
The headings and captions in this contract are not to be considered a part of this contract and are inserted only for purposes of convenience.

DEFINITIONS

This section defines terms which have special meanings. If a word or phrase has a special meaning or is a title, it may be capitalized. The word or phrase is defined in this section or at the place in the text where it is used.

Appeal: A formal request by you or your representative for reconsideration of a decision not resolved to your satisfaction. *See the Complaint and Appeals Procedures section of this contract.*

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 us, to be paid at the Network level. The Member may be responsible for the difference between the non-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 Conditions (including Substance Abuse): A condition identified as a mental disorder in the most current version of the *International Classification of Diseases*, in the chapter titled "Mental Disorders."

- Mental Health Disorders are conditions which manifest symptoms which are primarily mental or nervous, regardless of any underlying physical causes.
- Substance Abuse is a condition brought about when an individual uses alcohol or other drug(s) in such a manner that their health is impaired and/or ability to control actions is lost.

In determining whether or not a particular condition is a *Behavioral Health Condition*, this KYHC Plan may refer to the current edition of the Diagnostic and Statistical Manual of Mental Conditions of the American Psychiatric Association, or the International Classification of Diseases (ICD).

Benefit Period: The period of time that we pay benefits for covered services. The benefit period is listed in the *Schedule of Benefits*. If your coverage ends earlier, the benefit period ends at the same time.

Benefit Period Maximum: The maximum we pay for specific covered services during a benefit period.

Brand Name Drug: The initial version of a medication developed by a pharmaceutical manufacturer, or a version marketed under a pharmaceutical manufacturer's own registered trade name or trademark. The original manufacturer is granted an exclusive patent to manufacture and market a new drug for a certain number of years. After the patent expires, if FDA requirements are met any manufacturer can produce the drug and sell under its own brand name, or under the drug's chemical name (generic).

Copayment: A specific dollar amount of the Maximum Allowable Amount for covered services that are indicated in the *Schedule of Benefits*, which you must pay. The Copayment does not apply to any deductible that you are required to pay. Your Copayment will be the lesser of the amount shown in the *Schedule of Benefits* or the amount charged by the provider.

Coinsurance: A specific percentage of the Maximum Allowable Amount for covered services that are indicated in the *Schedule of Benefits*, which you must pay. Coinsurance normally applies after the Deductible that you are required to pay. *See the Schedule of Benefits for any exceptions.*

Contract: the contract between us and the Subscriber. It includes this contract, your *Schedule of Benefits*, your application, any supplemental application or change form, your identification card, and any endorsements or riders.

Covered services: Services, supplies or treatment as described in this contract which are performed, prescribed, directed or authorized by a provider. To be a covered service the service, supply or treatment must be:

- Medically Necessary or otherwise specifically included as a benefit under this contract.
- Within the scope of the license of the provider performing the service.
- Rendered while coverage under this contract is in force.
- Not Experimental/Investigative or otherwise excluded or limited by this contract, or by any amendment or rider thereto.

- Authorized in advance by us if such prior authorization is required in this contract.

A charge for a covered service is incurred on the date the service, supply or treatment was provided to you. The incurred date (for determining application of Deductible and other cost share amounts) for an inpatient admission is the date of admission except as otherwise specified in benefits after termination.

Covered services do not include any services or supplies that are not documented in provider records.

Covered Transplant Procedure: Any Medically Necessary human organ and tissue transplant, as determined by us, including necessary acquisition costs and preparatory myeloblative therapy.

Covered Transplant Services: All covered transplant procedures and all covered services directly related to the disease that has necessitated the covered transplant procedure or that arises as a result of the covered transplant procedure within a covered transplant benefit Period, including any diagnostic evaluation for the purpose of determining a Member's appropriateness for a covered transplant procedure.

Custodial Service or Care: Care primarily for the purpose of assisting you in the activities of daily living or in meeting personal rather than medical needs. Custodial care is not specific treatment for an illness or injury. Care which cannot be expected to substantially improve a medical condition and has minimal therapeutic value. Such care includes, but is not limited to:

- Assistance with walking, bathing, or dressing
- Transfer or positioning in bed
- Normally self-administered medicine
- Meal preparation
- Feeding by utensil, tube, or gastrostomy
- Oral hygiene
- Ordinary skin and nail care
- Catheter care
- Suctioning
- Using the toilet
- Enemas
- Preparation of special diets and supervision over medical equipment or exercises or over self-administration of oral medications not requiring constant attention of trained medical personnel.

Care can be custodial regardless of whether it is recommended by a professional or performed in a facility, such as a hospital or skilled nursing facility, or at home.

Deductible: The dollar amount of covered services, listed in the *Schedule of Benefits*, which you must pay for before we will pay for those covered services in each benefit period.

Dependent: A person of the Subscriber's family who is covered under the contract, as described in the "Eligibility and Enrollment" Section.

Diagnostic Service: A test or procedure performed on you or other person covered on this contract, who is displaying specific symptoms, to detect or monitor a disease or condition. A

diagnostic service also includes a Medically Necessary preventive care screening test that may be required for you or pother person on this contract who is not displaying any symptoms. However, this must be ordered by a provider. Examples of covered diagnostic services can be found in the “Covered Services” section.

Domiciliary Care: Care provided in a residential institution, treatment center, halfway house, or school because a Member’s own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

Effective Date: The date that a Subscriber’s coverage begins under this contract. A dependent’s coverage also begins on the Subscriber’s effective date.

Eligible Person: A person who satisfies this KYHC Plan's eligibility requirements and is entitled to apply to be a Subscriber or “covered person”.

Emergency: (Emergency medical Condition”) An accidental traumatic bodily injury or other medical condition that manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson to:

- Place your health, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
- Result in serious impairment to your bodily functions; or
- Result in serious dysfunction of one of your organs or body parts.

With respect to a pregnant woman who is having contractions, the absence of medical attention would reasonably be expected to result in:

- A situation in which there is inadequate time to effect a safe transfer to another hospital before delivery; or
- A situation in which transfer may pose a threat to the health or safety of the woman or the unborn child.

Emergency Care (Emergency Services): 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 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.

Enrollment Date: The first day of coverage, or, if there is a waiting period, the first day of the waiting period.

Experimental/Investigative: A drug, device or medical treatment or procedure that:

- has not been given approval for marketing by the United States Food and Drug Administration at the time it is furnished and such approval is required by law; or
- reliable evidence shows is the subject of ongoing phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its standard means of treatment or diagnosis. Reliable evidence means only the published reports and articles and authoritative medical and scientific literature, written protocol or protocols by the treating facility or other facility studying substantially the same drug, device or medical treatment or procedure; or the written informed consent used by the treating

facility or other facilities studying substantially the same drug, device or medical treatment or procedure.

We may consult with professional peer review committees or other appropriate sources for recommendations.

Family Coverage: Coverage for the Subscriber and eligible dependents.

Formulary: The list of pharmaceutical products, developed in consultation with physicians and pharmacists, approved for their quality and cost effectiveness.

Generic Drugs: Prescription drugs that have been determined by the FDA to be equivalent to brand name drugs, but are not made or sold under a registered trade name or trademark. Generic drugs have the same active ingredients, meet the same FDA requirements for safety, purity, and potency and must be dispensed in the same dosage form (tablet, capsule, cream) as the brand name drugs.

Identification Card / ID Card: A card issued by this KYHC Plan that bears the Member's name, identifies the membership by number, and may contain information about your coverage. It is important to carry this card with you.

Inpatient: A Member who receives care as a registered bed patient in a hospital or other provider where a room and board charge is made. It does not mean a Member who is placed under observation for fewer than24 hours.

Mail Service: Our prescription management program, which offers you a convenient means of obtaining maintenance medications by mail, if you take prescription drugs on a regular basis. Covered prescription drugs are ordered directly from the licensed pharmacy mail service which has entered into a reimbursement agreement with us, and sent directly to your home.

Maintenance Medications: Medications you take on a regular, recurring basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes.

Maximum Allowed Amount: The maximum amount that we will pay for covered services you receive. For more information, see the "Claims Payment" section.

Medically Necessary or Medical Necessity: Services rendered for the diagnosis or treatment of a condition that are accepted as being necessary and appropriate according to the prevalent standards of medical care practice. The level and amount of services must not be greater than is necessary and appropriate according to said standards; for example, Inpatient services are not Medically Necessary if the services could have been appropriately provided as outpatient services according to said standards. Services will not be considered Medically Necessary simply because they are rendered or prescribed by the Member's physician or other provider.

We may consult with professional peer review committees or other appropriate sources for recommendations. Medically Necessary services must be 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) performed in the least costly setting that is medically appropriate.

Medicare: The programs of health care for the aged and disabled established by Title XVIII of the Social Security Act, as amended.

Member: A Subscriber or dependent who has satisfied the eligibility conditions, applied for coverage, been approved by this KYHC Plan and for whom premium payment has been made. Members are sometimes called “you" or "your" in this contract.

Mental Health/Substance Abuse" Subcontractor: An organization or entity that this KYHC Plan has a contract with to provide administrative and claims payment services and/or covered services regarding Mental Health/Substance Abuse services under this contract. These administrative services may also be provided directly by this KYHC Plan.

Network Provider: A provider who has entered into a contractual agreement or is otherwise engaged by us, or with another organization which has an agreement with us, to provide covered services and certain administration functions for the Network associated with this contract.

Network Specialty Pharmacy: A pharmacy which has entered into a contractual agreement or is otherwise engaged by us to render specialty drug services, or with another organization which has an agreement with us, to provide specialty drug services and certain administrative function to you for the specialty pharmacy network.

Network Transplant Provider: A provider that has been designated as a “Center of Excellence” by us and/or a provider selected to participate as a Network transplant provider by a designee. 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.

New FDA Approved Drug Product or Technology: The first release of the brand name product or technology upon the initial FDA new drug approval. May include other applicable FDA approval processes for its biochemical composition and initial availability in the marketplace for the indicated treatment and use.

New FDA approved drug product or technology does not include:

- New formulations: a new dosage form or new formulation of an active ingredient already on the market;
- Already marketed drug product but new manufacturer: a product that duplicates another firm’s already marketed drug product (same active ingredient, formulation, or combination);
- Already marketed drug product, but new use: a new use for a drug product already marketed by the same or a different firm; or
- Newly introduced generic medication: generic medications contain the same active ingredient as their counterpart brand-named medications.

Non-Network Provider: A provider who has not entered into a contractual agreement with us for the Network associated with this contract. Providers who have not contracted or affiliated with our designated subcontractor(s) for the services they perform under this contract are also considered non-network providers.

Non-Network Specialty Pharmacy: Any pharmacy which has not entered into a contractual agreement nor is otherwise engaged by us to render specialty drug services, or with another organization which has an agreement with us, to provide specialty drug services to you for the specialty pharmacy network.

Non-Network Transplant Provider: Any provider that has NOT been designated as a "center of excellence" by Us or has not been selected to participate as a Network transplant provider by a designee.

Out of Pocket Limit: A specified dollar amount of expense incurred by a Member and/or family for covered services in a benefit period as listed on the *Schedule of Benefits*. When the out of pocket limit is reached for a Member and/or family, then no additional Deductibles, Coinsurance, and Copayments are required for that person and/or family unless otherwise specified in this contract and/or the *Schedule of Benefits.*

Outpatient: A Member who receives services or supplies, while not an inpatient.

Pharmacy and Therapeutics (P&T) Committee: A committee of physicians and pharmacists who review literature and studies which address the safety, efficacy, approved indications, adverse effects, contraindications, medical outcome, and pharmacoeconomics. The committee will develop, review and/or approve guidelines related to how and when certain drugs and/or therapeutic categories will be approved for coverage.

KYHC Plan (or We, Us, Our): Kentucky Health Cooperative, Inc., which provides benefits to Members for the covered services described in this contract.

Premium: The periodic charges due which the Subscriber must pay this KYHC Plan to maintain coverage.

Prescription Legend Drug, Prescription Drug, or Drug: A medicinal substance that is produced to treat illness or injury and is dispensed to outpatients. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that states, "Caution: Federal law prohibits dispensing without a prescription." Compounded (combination) medications, which contain at least one such medicinal substance, are considered to be prescription legend drugs. Insulin is considered a prescription legend drug under this contract.

Prescription Order: A legal request, written by a provider, for a prescription drug or medication and any subsequent refills.

Primary Care Physician ("PCP"): A Network provider who is a practitioner that specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network provider as allowed by this KYHC 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 services, supplies, treatment, and certain drugs and/or therapeutic categories to define and/or limit the conditions under which they will be covered. Prescription drugs and their criteria for coverage are defined by the P&T 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 this KYHC Plan approves. This includes any provider rendering services which are required by applicable state law to be covered when rendered by such provider. Providers include, but are not limited to, the following persons and facilities listed below. If you have a question about a provider not shown below, please call the number on the back of your ID card.

- **Alcoholism Treatment Facility:** A facility that mainly provides detoxification and/or rehabilitation treatment for alcoholism

- **Alternative Care Facility**: A non-hospital health care facility, or an attached facility designated as free standing by a hospital that this KYHC Plan approves, which provides outpatient services primarily for but not limited to:
  1. Diagnostic services such as Computerized Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI)
  2. Surgery
  3. Therapy services or rehabilitation.
-
- **Ambulatory Surgical Facility**: A facility, with an organized staff of physicians, that:
  1. Is licensed as such, where required;
  2. Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis;
  3. Provides treatment by or under the supervision of physicians and nursing services whenever the patient is in the facility;
  4. Does not provide inpatient accommodations; and
  5. Is not, other than incidentally, used as an office or clinic for the private practice of a physician or other professional provider.

- **Certified Advance Registered Nurse Practitioner**

- **Certified Nurse Midwife**: When services are supervised and billed for by an employer physician.

- **Certified Registered Nurse Anesthetist**: When services are performed in collaboration with a physician and billed by a certified facility or hospital.

- **Certified Surgical Assistant**

- **Chiropractor**

- **Day Hospital**: A facility that provides day rehabilitation services on an outpatient basis.

- **Dialysis Facility**: A facility provider which mainly provides dialysis treatment, maintenance or training to patients as an outpatient or at your home. It is not a hospital.

- **Home Health Care Agency**: A facility, licensed in the state in which it is located, which;
  1. Provides skilled nursing and other services on a visiting basis in the Member's home; and;

2. is responsible for supervising the delivery of such services under a plan prescribed and
3. approved in writing by the attending physician.

- **Home Infusion Facility**: A facility which provides a combination of:
  1. Skilled nursing services
  2. Prescription drugs
  3. Medical supplies and appliances

  in the home as home infusion therapy for Total Parenteral Nutrition (TPN), Antibiotic therapy, Intravenous (IV) Chemotherapy, Enteral Nutrition Therapy, or IV pain management.

- **Hospice**: A coordinated plan of home, inpatient and outpatient care which provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a physician. Care is available 24 hours a day, seven days a week. The hospice must meet the licensing requirements of the state or locality in which it operates.

- **Hospital**: A provider constituted, licensed, and operated as set forth in the laws that apply to hospitals, which:
  1. Provides room and board and nursing care for its patients;
  2. Has a staff with one or more physicians available at all times;
  3. Provides 24 hour nursing service;
  4. Maintains on its premises all the facilities needed for the diagnosis, medical care, and treatment of an illness or injury; and
  5. Is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

  The term “Hospital” does not include a provider, or that part of a provider, used mainly for:
  1. Nursing care
  2. Rest care
  3. Convalescent care
  4. Care of the aged
  5. Custodial care
  6. Educational care
  7. Treatment of mental health disorders
  8. Treatment of alcohol or drug abuse

- **Laboratory(Clinical)**

- **Licensed Practical Nurse**: When services are supervised and billed for by an employer physician.

- **Occupational Therapist**

- **Outpatient Psychiatric Facility**: A facility which mainly provides diagnostic and therapeutic services for the treatment of Mental Health Disorders on an outpatient basis.

- **Pharmacy**: An establishment licensed to dispense prescription drugs and other medications through a duly licensed pharmacist upon a physician's order. A pharmacy may be a Network provider or a non-network provider.

- **Physical Therapist**

- **Physician**: A legally licensed doctor of medicine, doctor of osteopathy (bones and muscles), dental surgeon (teeth), podiatrist (diseases of the foot) or surgical chiropodist (surgical foot specialist) or ophthalmologist (eye and sight specialist);

- **Psychiatric Hospital**: A facility that, for compensation of its patients, is primarily engaged in providing diagnostic and therapeutic services for the Inpatient treatment of Mental Health Disorders. Such services are provided, by or under the supervision of, an organized staff of physicians. Continuous nursing services are provided under the supervision of a registered nurse.

- **Psychologist**: A licensed clinical psychologist. In states where there is no licensure law, the psychologist must be certified by the appropriate professional body.

- **Registered Nurse**

- **Registered Nurse First Assistant**

- **Registered Nurse Practitioner**

- **Regulated Physician's Assistant**: When services are supervised and billed for by an employer physician.

- **Rehabilitation Hospital**: A facility that is primarily engaged in providing rehabilitation services on an inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve some reasonable level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

- **Respiratory Therapist (Certified)**

- **Skilled Nursing Facility**: A provider constituted, licensed, and operated as set forth in applicable state law, which:

    1. mainly provides Inpatient care and treatment for persons who are recovering from an illness or injury;
    2. provides care supervised by a physician;
    3. provides 24hour per day nursing care supervised by a full-time registered nurse;
    4. is not a place primarily for care of the aged, custodial or domiciliary care, or treatment of alcohol or drug dependency; and
    5. is not a rest, educational, or custodial provider or similar place.

- **Social Worker**: A licensed clinical social worker. In states where there is no licensure law, the social worker must be certified by the appropriate professional body.

- **Speech Therapist**

- **Supplier of Durable Medical Equipment, Prosthetic Appliances and/or Orthotic Devices**

- **Urgent Care Center**: A licensed health care facility that is organizationally separate from a hospital and whose primary purpose is the offering and provision of immediate, short-term medical care, without appointment, for urgent care.

Record: means any written, printed, or electronically recorded material maintained by a provider in the course of providing health services to a patient concerning the patient and the services provided. Includes the substance of any communication made by a patient to a provider in confidence during or in connection with the provision of health services to a patient or information otherwise acquired by the provider about a patient in confidence and in connection with the provision of health services to a patient

Recovery: A recovery is money you receive from another, their insurer or from any "Uninsured Motorist", "Underinsured Motorist", "Medical-Payments", "No-Fault", or "Personal Injury Protection" or other insurance coverage provision as a result of injury or illness caused by another. Regardless of how you or your representative or any agreements characterize the money you receive, it shall be subject to the Subrogation and Reimbursement provisions of this KYHC Plan.

Service Area: The geographical area where our covered services are available, as approved by the Commonwealth of Kentucky regulatory agencies.

Single Coverage: Coverage that is limited to the Subscriber only.

Skilled Care: Care which is Medically Necessary and must be performed or supervised by a skilled licensed professional in the observation and/or assessment of treatment of an illness or injury. It is ordered by a physician and usually involves a treatment plan.

Specialty Care Physician (SCP): A Network provider, other than a primary care physician, who provides services within a designated specialty area of practice.

Stabilize: The provision of medical treatment to you in an emergency as may be necessary to assure, within reasonable medical probability that material deterioration of your condition is not likely to result from or during any of the following:

- Your discharge from an emergency department or other care setting where emergency care is provided to you
- Your transfer from an emergency department or other care setting to another facility; or
- Your transfer from a hospital emergency department or other hospital care setting to the hospital' s Inpatient setting.

Subcontractor: This KYHC Plan may subcontract particular services to organizations or entities health and substance abuse services. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on our behalf.

Subscriber: An eligible person in whose name this contract has been issued, whose coverage is in effect and whose name appears on the identification card as Subscriber.

Tele-health Services: The use of interactive audio, video, or other electronic media to deliver health care. It includes the use of electronic media for diagnosis, consultation, treatment, transfer of medical data, and medical education. A tele-health consultation shall not be reimbursable if it is provided through the use of an audio-only telephone, facsimile machine, or electronic mail.

Therapy Services: Services and supplies used to promote recovery from an illness or injury. covered therapy Services are limited to those services specifically listed in the "Covered Services" section.

Utilization Management: means a system for reviewing the appropriate and efficient allocation of health care services under a health benefits plan according to specified guidelines, in order to recommend or determine whether, or to what extent, a health care service given or proposed to be given to a covered person should or will be reimbursed, covered, paid for, or otherwise provided under the plan. The system may include preadmission certification, the application of practice guidelines, continued stay review, discharge planning, preauthorization of ambulatory care procedures, and retrospective review.

MANDATORY COVERED PREVENTIVE SERVICES

Covered Preventive Services for All Adults

1. **Abdominal Aortic Aneurysm**: one-time screening for men of specified ages who have ever smoked
2. **Alcohol Misuse** screening and counseling
3. **Aspirin** use for men and women of certain ages
4. **Blood Pressure** screening for all adults
5. **Cholesterol** screening for adults of certain ages or at higher risk
6. **Colorectal Cancer** screening for adults over 50
7. **Depression** screening for adults
8. **Type 2 Diabetes** screening for adults with high blood pressure
9. **Diet** counseling for adults at higher risk for chronic disease
10. **HIV** screening for all adults at higher risk
11. **Immunization** vaccines for adults--doses, recommended ages, and recommended populations vary:
    a. Hepatitis A

b. Hepatitis B
c. Herpes Zoster
d. Human Papillomavirus
e. Influenza (Flu Shot)
f. Measles, Mumps, Rubella
g. Meningococcal
h. Pneumococcal
i. Tetanus, Diphtheria, Pertussis
j. Varicella

12. **Obesity** screening and counseling for all adults
13. **Sexually Transmitted Infection (STI)** prevention counseling for adults at higher risk
14. **Tobacco Use** screening for all adults and cessation interventions for tobacco users
15. **Syphilis** screening for all adults at higher risk

****Covered Preventive Services for Women, Including Pregnant Women****

1. **Anemia** screening on a routine basis for pregnant women
2. **Bacteriuria** urinary tract or other infection screening for pregnant women
3. **BRCA** counseling about genetic testing for women at higher risk
4. **Breast Cancer Mammography** screenings every 1 to 2 years for women over 40
5. **Breast Cancer Chemoprevention** counseling for women at higher risk
6. **Breastfeeding** comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women*
7. **Cervical Cancer** screening for sexually active women
8. **Chlamydia Infection** screening for younger women and other women at higher risk
9. **Contraception:** Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs*
10. **Domestic and interpersonal violence** screening and counseling for all women*
11. **Folic Acid** supplements for women who may become pregnant
12. **Gestational diabetes** screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes*

13. **Gonorrhea** screening for all women at higher risk
14. **Hepatitis B** screening for pregnant women at their first prenatal visit
15. **Human Immunodeficiency Virus (HIV)** screening and counseling for sexually active women*
16. **Human Papillomavirus (HPV) DNA Test:** high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older*
17. **Osteoporosis** screening for women over age 60 depending on risk factors
18. **Rh Incompatibility** screening for all pregnant women and follow-up testing for women at higher risk
19. **Tobacco Use** screening and interventions for all women, and expanded counseling for pregnant tobacco users
20. **Sexually Transmitted Infections (STI)** counseling for sexually active women*
21. **Syphilis** screening for all pregnant women or other women at increased risk
22. **Well-woman visits** to obtain recommended preventive services*

****Covered Preventive Services for Children****

1. **Alcohol and Drug Use** assessments for adolescents
2. **Autism** screening for children at 18 and 24 months
3. **Behavioral** assessments for children of all ages
   Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
4. **Blood Pressure** screening for children
   Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
5. **Cervical Dysplasia** screening for sexually active females
6. **Congenital Hypothyroidism** screening for newborns
7. **Depression** screening for adolescents
8. **Developmental** screening for children < 3, and surveillance throughout childhood
9. **Dyslipidemia** screening for children at higher risk of lipid disorders
   Ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
10. **Fluoride Chemoprevention** supplements for children without fluoride in their water
11. **Gonorrhea** preventive medication for the eyes of all newborns
12. **Hearing** screening for all newborns

13. **Height, Weight and Body Mass Index** measurements for children

    Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
14. **Hematocrit or Hemoglobin** screening for children
15. **Hemoglobinopathies** or sickle cell screening for newborns
16. **HIV** screening for adolescents at higher risk
17. **Immunization** vaccines for children from birth to age 18 —doses, recommended ages, and recommended populations vary:
    a. Diphtheria, Tetanus, Pertussis
    b. Haemophilus influenzae type b
    c. Hepatitis A
    d. Hepatitis B
    e. Human Papillomavirus
    f. Inactivated Poliovirus
    g. Influenza (Flu Shot)
    h. Measles, Mumps, Rubella
    i. Meningococcal
    j. Pneumococcal
    k. Rotavirus
    l. Varicella
18. Educate about immunizations
19. **Iron** supplements for children ages 6 to 12 months at risk for anemia
20. **Lead** screening for children at risk of exposure
21. **Medical History** for all children throughout development

    Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
22. **Obesity** screening and counseling
23. **Oral Health** risk assessment for young children

    Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years.
24. **Phenylketonuria (PKU)** screening for this genetic disorder in newborns
25. **Sexually Transmitted Infection (STI)** prevention counseling and screening for adolescents at higher risk
26. **Tuberculin** testing for children at higher risk of tuberculosis

    Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
27. **Vision** screening for all children