The University of Kentucky

Self-funded Student Health Plan

I. General Information

This self-funded Student Health Plan (SHP or Plan) is maintained by the University of Kentucky for the benefit of eligible students. The benefits available to students are set forth in this Plan Document. If other documents used to communicate benefits under this Student Health Plan conflict with this document, this document will prevail.

Certain categories of students may be required to contribute some or all of the actuarially determined Premium rates for coverage under the Student Health Plan. Premium rates will be established for each Plan Year, and will be published by the University prior to the beginning of each Plan Year.

The University contracts with certain organizations to provide certain services to the University and Covered Individuals. These organizations include:

Student Health Plan Manager: Academic HealthPlans, Inc. (AHP)

Claims Administrator: ARC Administrators

In-Network Providers (Provider Network): Anthem, and Blue Card Access

Pharmacy Benefit Manager (PBM): Express Scripts

In-network Pharmacies (Pharmacy Network): Express Scripts

Pediatric Dental and Vision Benefits Network: UK HealthCare

These organizations, along with the University Health Service, also provide the Plan with services for “Ensuring the Quality of Care”. These services include, but are not limited to 1) care coordination and chronic disease management, and 2) smoking cessation resources.

II. Eligibility and Coverage

Your eligibility for coverage under this Plan is determined entirely by your status as a student at the University of Kentucky. An eligible student may also cover an eligible spouse and eligible children. Your coverage will remain in effect (except in cases of fraud) for a chosen Coverage Period as long as you have paid any required premiums, and you meet the minimum Plan eligibility requirements as a student. You may enroll in subsequent Coverage Periods as long as you maintain the minimum eligibility requirements as a student, and pay any required Premium.

Newborn Infants will be covered under the Plan for the first 31 days after birth. Coverage for Newborn Infants will be the same as for the Covered Individual who is the child's parent.

An Adopted Child will be covered from the moment of placement for the first 31 days. The Covered Individual must notify the Student Health Plan Manager, in writing, of the Adopted Child not more than 30 days after placement or adoption. In the case of a newborn adopted child, coverage begins at the moment of birth if a written agreement to adopt such child has been entered into by the Covered Individual prior to the birth of the child, whether or not the agreement is enforceable. However, coverage will not continue to be provided for an adopted child who is not ultimately placed in the Covered Individual's residence. The Covered Individual will have the right to continue such coverage for the child beyond the first 31 days. To continue the coverage the Covered Individual must, within the 31 days after the child's date of placement: 1) apply for coverage; and 2) pay the required additional Premium, if any, for the continued coverage. If the Covered Individual does not use this right as stated here, all coverage as to that child will terminate at the end of the first 31 days after the child's date of placement.

If a Covered Individual is confined as an Inpatient in a Hospital on the date the Coverage Period would otherwise end, the Coverage Period will be extended until the date the Covered Individual is discharged from the Hospital.

Your coverage, and coverage for your eligible spouse and children who are also covered on the Termination Date, may be extended for up to three (3) additional months past the Termination Date of your coverage, if you no longer meet the eligibility requirements of the Plan, provided:

1. You notify the University, prior to the Termination Date, of your intention to continue the coverage, and
2. You pay the required Premium for the continuation of coverage Coverage Period.

If the continuation of coverage Coverage Period extends into a subsequent Plan Year, the Covered Individual is required to pay the required Premium, or pro rata portion of the required Premium, that is applicable in the subsequent Plan Year. The portion of the continuation of coverage Coverage Period that extends into the subsequent Plan Year is subject to the benefits offered under the Plan during the subsequent Plan Year.

A dependent child may be covered under the Plan until his or her the 26th birthday, and coverage will terminate on the 26th birthday even if the 26th birthday occurs during the continuation Coverage Period.

The Plan does not impose any limitations on pre-existing conditions for any Essential Health Benefits.

Voluntary Enrollment Group – Undergraduate and non-funded graduate students may purchase coverage provided by this health plan. An undergraduate student must be enrolled in at least six (6) credit hours at the University of Kentucky or Bluegrass Community and Technical College (BCTC) campuses located at Cooper, Regency and Leestown. A non-funded graduate student must be enrolled in any course with the university. Students in the Voluntary Enrollment Group are required to pay the full Premium for the Coverage Period chosen.

International Students – Health insurance is mandatory at UK for international students. F-1, J-1, and J-2 students are enrolled in the Student Health Plan automatically. The premium (cost) for this health plan is automatically added to the international student's bill when he or she registers for any class (including zero or two-credit hour courses).

If the student already has other insurance coverage and does not wish to enroll in the SHP, the student may be eligible to waive SHP coverage. When a waiver is approved for a qualifying alternate plan, UK will cancel that student's eligibility for the SHP for one semester. Waivers must be completed each semester in order to cancel the SHP charge. Coverage in the SHP may only be waived for:

- Students with health coverage provided by an employer,
- Students with health coverage provided by a government sponsor, or
- Exchange students with health coverage provided by the organization coordinating their exchange.

Funded Graduate Assistants – A qualifying funded graduate student is automatically enrolled in the coverage provided by this health plan. To qualify, a student must be enrolled in the Graduate School, degree-seeking, and receiving support from UK in the form of a Full-time Assistantship (TA, RA, GA), qualifying fellowship, or a combination of these positions. Full-time Assistantship standing means an assignment of 20 hours per week or a fellowship stipend of $9,000 or more paid through the UK payroll system. The SHP Office determines eligibility each semester. Changes with a student's assignment, fellowship, or status may affect his or her eligibility. Summer health plan coverage is linked to the funded graduate student's status in the spring semester preceding the summer term(s).

III. Definitions

1. **Coinsurance** means the percentage of Covered Medical Expenses that the Covered Individual pays.
2. **Copay** means an amount specified in the Schedule of Benefits that is collected at the time of service by the health care provider or pharmacy. Copays are collected by providers even if the Deductible has not been satisfied. Copays are not collected by providers once the Covered Individual has met the Out-of-pocket Limit.
3. **Coverage Period** means a period of time a person is a Covered Individual. Several Coverage Period options are made available to eligible students. A Coverage Period may be annual, based on semesters or combinations of semesters, or another specified period. Premiums vary based on the relative length of each Coverage Period (as well as other factors).
4. **Covered Medical Expense** means reasonable charges which are: 1) not in excess of Usual and Customary Charges or contracted amounts with Preferred Providers or In- network Providers; 2) fees charged for services available at University Health Service; 3) not in excess of the maximum benefit amount payable per service as specified in the Schedule of Benefits; 4) made for services and supplies not excluded under the Plan; 5) made for services and supplies which are Medically Necessary; 6) made for services included in the Schedule of Benefits; and 6) in excess of the amount stated as a Deductible, if any. Covered Medical Expenses will be deemed "incurred" only: 1) when the covered services are provided; and 2) when a charge is made to the Covered Individual for such services.
5. **Deductible** and **Per-service Deductible** means an amount, specified in Medical and Prescription Drug Benefits**,** to be subtracted from the amount or amounts otherwise payable as Covered Medical Expenses before payment of any benefit is made. The deductible will apply per Plan Year or per occurrence (for each Injury) as specified in Medical and Prescription Drug Benefits.
6. **Effective Date** means the date a person becomes a Covered Individual under this Student Health Plan.
7. **Elective Surgery or Elective Treatment** means those health care services or supplies that do not meet the health care need for an Illness or Injury. Elective Surgery or Elective Treatment includes any service, treatment or supplies that: 1) are deemed to be for research or experimental; or 2) are not recognized and generally accepted medical practices in the United States.
8. **Essential Health Benefits** means the benefits that must be offered in the state of Kentucky according to the provisions of the Patient Protection and Affordable Care Act (the ACA).
9. **Hospital** means a licensed or properly accredited general hospital which: 1) is open at all times; 2) is operated primarily and continuously for the treatment of and surgery for sick and injured persons as inpatients; 3) is under the

supervision of a staff of one or more legally qualified Physicians available at all times; 4) continuously provides on the premises 24 hour nursing service by Registered Nurses; 5) provides organized facilities for diagnosis and major surgery on the premises; and 6) is not primarily a clinic, nursing, rest or convalescent home, or an institution specializing in or primarily treating Mental and Nervous Disorder.

10. **Hospital Confined/Hospital Confinement** means confined in a Hospital for at least 23 hours by reason of an Injury or Illness for which benefits are payable.
11. **Illness** means illness, sickness, condition, syndrome or disease of a Covered Individual that causes a financial loss while the Covered Individual is covered under this Plan. All related conditions and recurrent symptoms of the same or a similar condition will be considered one Illness. Covered Medical Expenses incurred as a result of an Injury that occurred prior to the Covered Individual's Effective Date will be considered an Illness under this Plan.
12. **Injury** means bodily injury which is: 1) directly and independently caused by specific accidental contact with another body or object; 2) unrelated to any pathological, functional, or structural disorder; 3) a source of loss; 4) treated by a Physician within 30 days after the date of accident; and 5) sustained while the Covered Individual is covered under this Plan. All injuries sustained in one accident, including all related conditions and recurrent symptoms of these injuries will be considered one injury. Injury does not include loss which results wholly or in part, directly or indirectly, from disease or other bodily infirmity. Covered Medical Expenses incurred as a result of an injury that occurred prior to this Plan's Effective Date will be considered a Illness under this Plan.
13. **In-network Provider** means any provider in the Provider Network specified in the General Information section of this Plan Document.
14. **Covered Individual** means a student, or legal spouse or dependent child of a student, who meets the eligibility requirements of the Student Health Plan, has completed the enrollment process, and has paid the required Premium.
15. **Premium** means the amount a Covered Individual is required to pay for a specified Coverage Period under the Student Health Plan**.**
16. **Intensive Care or Intensive Care Unit** means: 1) a specifically designated facility or unit of the Hospital that provides the highest level of medical care; and 2) which is restricted to those patients who are critically ill or injured. Such facility must be separate and apart from the surgical recovery room and from rooms, beds, wards or units customarily used for patient confinement. They must be:1) permanently equipped with special life-saving equipment for the care of the critically ill or injured; and 2) under constant and continuous observation by nursing staff assigned on a full-time basis, exclusively to the Intensive Care Unit. Intensive Care does not mean any of the following step-down or specialty care units: 1) progressive care; 2) sub-acute intensive care;

3) intermediate care units; 4) private monitored rooms; 5) observation units; or 6) other facilities which do not meet the standards for intensive care.

17. **Medical Emergency** means the occurrence of a sudden, serious and unexpected Illness or Injury. In the absence of immediate medical attention, a reasonable person could believe this condition would result in: 1) death; 2) jeopardizing the Covered Individual's health; 3) serious impairment of bodily functions; 4) serious dysfunction of any body organ or part; or 5) in the case of a pregnant woman, serious jeopardy to the health of the fetus. Expenses incurred for a Medical Emergency will be paid only for Illness or Injury which fulfills the above conditions. These expenses will not be paid for minor Injuries or minor Illnesses.
18. **Medical Necessity** or **Medically Necessary** means those services or supplies provided or prescribed by a Hospital or Physician which are: 1) essential for the symptoms, diagnosis or treatment of the Injury or Illness; 2) provided for the diagnosis, or the direct care and treatment of the Injury; 3) In accordance with the standards of good medical practice; 4) not primarily for the convenience of the Covered Individual, or the Covered Individual's Physician; and, 5) the most appropriate supply or level of service which can safely be provided to the Covered Individual. The Medical Necessity of being Hospital Confined means that: 1) the Covered Individual requires acute care as a bed patient; and, 2) the Covered Individual cannot receive safe and adequate care as an outpatient. This self-funded health plan only provides payment for services, procedures and supplies which are a Medical Necessity. No benefits will be paid for expenses which are determined not to be a Medical Necessity, including any or all days of Hospital Confinement.
19. **Newborn Infant** means any child born of a covered student or legal spouse of a covered student while that person is a Covered Individual under this Student Health Plan.
20. **Out-of-network Providers** means providers who are not a part of the UK HealthCare (Preferred Providers) and are not included in the list of In-network Providers. Out-of-network Providers have no contractual relationship with the Student Health Plan. If an Out-of-network provider charges an amount in excess of the Usual and Customary charge for a service, the covered individual will be responsible for the excess amount and the excess amount will not be counted toward satisfying the Covered Individual's Out-of-pocket Limit.
21. **Out-of-pocket Maximum** means the total amount of Covered Charges that a Covered Individual is required to pay during the Plan Year. The Out-of-pocket Maximum includes Deductibles, Per-Service Deductibles, Copays, and Coinsurance. The Out-of-pocket Maximum does not include charges that are not Covered Medical Expenses under the plan, penalties for failing to follow the Plan requirements, or Premiums.

22. **Physician** means a legally qualified licensed practitioner of the healing arts who provides care within the scope of his or her license, and is not a member of the person's immediate family. A "member of the immediate family" means any person related to a Covered Individual within the third degree by the laws of consanguinity or affinity.
23. **Physiotherapy** means any form of the following: physical or mechanical therapy; diathermy; ultra-sonic therapy; heat treatment in any form; manipulation or massage administered by a Physician.
24. **Plan Year** means the period that begins on August 15 of the calendar year and ends on August 14 of the immediately following calendar year, and corresponds to the academic year. The dates on which the Plan Year begins and ends may be changed slightly from time to time to correspond with changes in the academic year.
25. **Preferred Provider** means any UK HealthCare provider.
26. **Prescription Drug or Prescription Drug Product** means: 1) prescription legend drugs; 2) compound medications of which at least one ingredient is a prescription legend drug; 3) any other drugs which under the applicable state or federal law may be dispensed only upon written prescription of a Physician; and 4) injectable insulin.
27. **Registered Nurse** means a professional nurse (R.N.) who is not a member of the Covered Individual's immediate family.
28. **Sound, Natural Teeth** means natural teeth, the major portion of the individual tooth is present, regardless of fillings or caps; and is not carious, abscessed, or defective.
29. **Usual and Customary Charges** means a reasonable charge which is: 1) usual and customary when compared with the charges made for similar services and supplies; and 2) made to persons having similar medical conditions in the locality where service is rendered. No payment will be made under this Plan for any expenses incurred which in the judgment of the Claims Administrator are in excess of Usual and Customary Charges.
30. **Complication of Pregnancy** means a condition: 1) caused by pregnancy; 2) requiring medical treatment prior to, or subsequent to termination of pregnancy; 3) the diagnosis of which is distinct from pregnancy; and 4) which constitutes a classifiably distinct complication of pregnancy. A condition simply associated with the management of a difficult pregnancy is not considered a complication of pregnancy.
31. **Adopted Child** means the adopted child placed with a Covered Individual while that person is covered under this Plan.

IV. Medical and Prescription Drug Benefits

	In-network Providers			Out-of-network Providers
	University Health Service	**UK HealthCare Providers (Preferred Providers)**	**Other In-network Providers**	
Annual Deductible	None	$100	$500	$1,000
Benefit Percentage (Coinsurance)	100% (0%)	80% (20%)	65% (35%)	50% (50%)
Preventive Health Services	Covered at 100%			Deductible and Coinsurance
Out-of-pocket Limit (includes all copays and deductibles)	$6,350 ($12,700 Family)			
Maximum Benefit on Essential Health Benefits	Unlimited			
Rx – Tier 1	$10	$10	$30	$30 Per-Service (prescription) Deductible for Generic drugs, $50 Per-service (prescription) Deductible for Brand-name drugs, then the Plan pays 70% of Usual and Customary Charges (30% Coinsurance)
Rx – Tier 2	$30	$30	$50	
Rx – Tier 3	$75	$75	$75	

When care is received from a UK HealthCare Preferred Provider, benefits will be paid at the Preferred Provider level of benefits. When care is received from an In-Network Provider, Covered Medical Expenses will be paid at the In-Network level of benefits. When care is received from an Out-of-network Provider the benefits will be paid at the Out-of-network Provider level of benefits.

After the Out-of-Pocket Maximum has been satisfied, Covered Medical Expenses will be paid at 100% for the remainder of the Plan Year, subject to any benefit maximums or limits that may apply. All Copays, the Deductible, and any Per-service Deductibles, will be applied to the Out-of-Pocket Maximum. Services that are not Covered Medical Expenses and any amount benefits are reduced for failing to comply with Plan provisions or requirements do not count toward meeting the Out-of- Pocket Maximum.

All Copays and Per-service Deductibles specified in the Schedule of Benefits are in addition to the Deductible, and will be collected from Covered Individuals whether or not the Deductible has been satisfied. If no Copay or Per-service Deductible is specified, the Deductible must be satisfied before any benefits will be paid.

Special University Health Service (UHS) benefits: For services received from UHS**,** the Deductible will be waived and benefits will be paid at 100% of Covered Medical Expenses. Copays apply to all prescriptions filled at UHS. The following services are available at UHS:

1. Physician visits
2. Mental Illness and substance use disorder treatment visits
3. Care for an Injury requiring minor surgical procedure (Example: suturing of laceration; casting of a simple fracture)
4. Outpatient surgery (Example: incision and drainage of an abscess; biopsy)
5. Colposcopy
6. Cost of some laboratory tests
7. Prescription Drugs (Copays apply)
8. Cost of the following immunization vaccines when administered within medical guidelines and schedule: Measles, Mumps, Rubella, Tetanus, Diphtheria, Pertussis, Polio, Varicella, Influenza, HPV, Hepatitis A, Hepatitis B series, Meningococcal Meningitis, Herpes Zoster and Pneumococcal.
9. Women's Preventive Services
10. Treatment and supplies for programs involving cessation of tobacco use

IMPORTANT! In-network providers are subject to change without notice. Before you seek care you should visit the Student Health Plan Manager's Web Site uky.myahpcare.com for a link to In-network Providers and Pharmacies.

Benefits are calculated on a Plan Year basis unless otherwise specifically stated. When benefit limits apply, benefits will be paid up to the maximum benefit for each service as scheduled below. All benefit maximums are combined Preferred Provider, In-Network and Out-of-Network, unless otherwise specifically stated. Unless otherwise specifically stated, the Deductible and Coinsurance will be applied to the Covered Medical Expenses will be treated the same as any other Illness or Injury.

A. Inpatient Services:
    1. Room & Board - The daily semi-private room rate when confined as an Inpatient and general nursing care is provided and charged by the Hospital.
    2. Intensive Care
    3. Hospital Miscellaneous Expenses – Covered when confined as an Inpatient or as a precondition for being confined as an Inpatient. In

computing the number of days that are payable under this benefit, the date of admission will be counted, but the date of discharge will not be counted. Benefits will be paid for services and supplies such as:

a. The cost of the operating room.
b. Laboratory tests.
c. X-ray examinations.
d. Anesthesia.
e. Drugs (excluding take home drugs) or medicines.
f. Therapeutic services.
g. Supplies.

4. Routine Newborn Infant Care – Covered while Hospital Confined and routine nursery care is provided immediately after birth. Benefits will be paid for an inpatient stay of at least 48 hours following a vaginal delivery and 96 hours following a cesarean section delivery. If the mother agrees, the attending Physician may discharge the Newborn Infant earlier than these minimum time frames.
5. Surgery – Physicians fees in connection with Inpatient surgery. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.
6. Assistant Surgeon Fees
7. Anesthetist or Anesthesiologist Services
8. Registered Nurse's Services – Covered for services which are for private duty nursing care only, received while confined as an Inpatient, ordered by a Physician, and are a Medical Necessity. General nursing care provided by the Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility is not covered under this benefit.
9. Physician's Visits – For non-surgical Physician services while confined as an Inpatient.
10. Pre-admission Testing – Pre-admission testing must occur within 7 days prior to admission. Benefits are limited to routine tests such as complete blood count, urinalysis, and Chest X-rays. If otherwise payable under the Plan, major diagnostic procedures such as CT scans, NMR’s, and blood chemistries will be paid under the “Hospital Miscellaneous” benefit.

B. <u>Outpatient Services:</u>

1. Surgery – If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.
2. Day Surgery Miscellaneous – Day Surgery Miscellaneous charges are based on the Outpatient Surgical Facility Charge Index, and include the facility charge and the charge for services and supplies in

connection with outpatient day surgery, excluding non-scheduled surgery; and surgery performed in a Hospital emergency room; trauma center; Physician's office; or clinic. Coverage shall be provided for health care treatment or services rendered by ambulatory surgical centers approved by the Kentucky health facilities and health services certificate of need and licensure board. The coverage for health care treatment or services rendered by an ambulatory surgical center shall be on the same basis as coverage provided for the same health care treatment or services rendered by a Hospital.

3. Assistant Surgeon Fees
4. Anesthetist or Anesthesiologist Services
5. Physician's Visits – Services provided in a Physician's office for the diagnosis and treatment of an Illness or Injury. Benefits do not apply when related to surgery or Physiotherapy. Physician's Visits for preventive care are provided as specified under Preventive Care Services.
6. Physiotherapy, Out-patient Rehabilitation Services – A $15 Copay per visit will be collected by Preferred Providers and In-network Providers. A $15 Per-service Deductible will be applied for each visit to an Out-of-network Provider. The Copay or Per-service Deductible will be waived when treatment follows surgery or Hospital Confinement. A review of Medical Necessity will be performed after 12 visits associated with each Injury or Illness. Benefits for Physiotherapy includes but is not limited to the following rehabilitative services (including Habilitative Services):
    a. Physical therapy.
    b. Occupational therapy.
    c. Cardiac rehabilitation therapy.
    d. Manipulative treatment.
    e. Speech therapy. Other than as provided for Habilitative Services, speech therapy will be paid only for the treatment of speech, language, voice, communication and auditory processing when the disorder results from Injury, trauma, stroke, surgery, cancer, or vocal nodules or autism spectrum disorder.

    Any visit limits for physical therapy, occupational therapy, and speech therapy do not apply to the treatment of autism spectrum disorder.
7. Medical Emergency Expenses – A $75 Copay per visit will be collected by UK HealthCare providers. A $150 Copay per visit will be collected by In-network Providers. A $250 Per-service Deductible will be applied for each visit to an Out-of-network Provider. The Copay or Per-service Deductible will be waived if admitted to the Hospital. Treatment must be rendered within 72 hours from the time of Injury or first onset of Illness. The Deductible and coinsurance applies if the Covered Individual is admitted to the Hospital. Only services in connection with a Medical Emergency will be paid under this benefit. Benefits will be paid for the facility charge for

use of the emergency room and supplies. Any other services not in connection with a Medical Emergency received during the visit will be paid as any other Illness or Injury.

8. Diagnostic X-ray Services – Diagnostic X-rays are any covered X-ray procedures that are not specifically covered under X-ray services for preventive care as specified under Preventive Care Services.
9. Radiation Therapy – If radiation does not follow surgery, a $15 Copay per visit will be collected by Preferred Providers and In-network Providers. If radiation does not follow surgery, a $15 Per-service Deductible will be applied for each visit to an Out-of-network Provider.
10. Laboratory Procedures – Laboratory Procedures are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 80000 - 89999 inclusive. Laboratory procedures for preventive care are provided as specified under Preventive Care Services.
11. Tests & Procedures – Tests and procedures are those diagnostic services and medical procedures performed by a Physician but do not include Physician's Visits, physiotherapy, X-rays, or Laboratory Procedures. Tests and Procedures for preventive care are provided as specified under Preventive Care Services. The following therapies will be paid under the Tests and Procedures (Outpatient) benefit:
    a. Inhalation therapy
    b. Infusion therapy
    c. Pulmonary therapy
    d. Respiratory therapy
12. Injections – Covered when administered in the Physician's office and charged on the Physician's statement. Immunizations for preventive care are provided as specified under Preventive Care Services.
13. Chemotherapy – If chemotherapy does not follow surgery, a $15 Copay per visit will be collected by Preferred Providers and In-network Providers. If chemotherapy does not follow surgery, a $15 Per-Service Deductible will be applied for each visit to an Out-of-network Provider.

C. <u>Prescription Drugs:</u>

1. University Health Service – A $10 Copay per prescription for Tier 1 drugs will be collected by the pharmacy at the time of purchase. A $30 Copay per prescription for Tier 2 drugs will be collected by the pharmacy at the time of purchase. A $75 Copay per prescription for Tier 3 drugs will be collected by the pharmacy at the time of purchase. Each prescription is limited to a 30-day supply.
2. Kentucky Clinic Pharmacy – A $10 Copay per prescription for Tier 1 drugs will be collected by the pharmacy at the time of purchase. A $30 Copay per prescription for Tier 2 drugs will be collected by the pharmacy at the time of purchase. A $75 Copay per prescription for Tier 3 drugs will be

collected by the pharmacy at the time of purchase. Each prescription is limited to a 30-day supply.

3. In-network Pharmacies – A $30 Copay per prescription for Tier 1 drugs will be collected by the pharmacy at the time of purchase. A $50 Copay per prescription for Tier 2 drugs will be collected by the pharmacy at the time of purchase. A $75 Copay per prescription for Tier 3 drugs will be collected by the pharmacy at the time of purchase. Each prescription is limited to a 30-day supply.
4. Mail Order Prescription Drugs – A 90-day supply of prescription drugs may be obtained from a Mail Order Pharmacy. The Covered Individual will pay two (2) times the In-network Pharmacy copay for the appropriate Tier for each 90-day supply.
5. Out-of-network Pharmacy – A $30 Per-service Deductible will be applied to each prescription for generic prescription drugs. A $50 Per-service Deductible will be applied to each prescription for brand-name prescription drugs. After the application of the Per-service Deductible, the Student Health Plan will pay 70% of the Usual and Customary Charge for the prescription drug. Each prescription is limited to a 30-day supply.

Benefits for Prescription Drugs are managed completely by the Pharmacy Benefit Manager. The basic Prescription Drug benefits are described in this Prescription Drugs section. Specific details of managing the Prescription Drug benefit are delegated to Express Scripts, including, but not limited to:

- Establishing specific Supply Limits
- Determining which Prescription Drugs or Prescription Drug Products are categorized as Tier 1, Tier 2, and Tier 3
- Monitoring changes in drug status (e.g., when a brand name drug becomes a generic drug, and the Tier level changes)
- Which pharmacies are In-network pharmacies (other than Kentucky Clinic Pharmacy)

Complete details are available from the Pharmacy Benefit Manager, and a link may be found on the Student Health Plan Manager's Web Site at uky.myahpcare.com.

For Prescription Drug Products at a retail In-network Pharmacy, Covered Individuals are responsible for paying the lower of:

1. The applicable Copay, or Per-Service Deductible and Coinsurance; or
2. The Network Pharmacy's Usual and Customary Fee for the Prescription Drug Product.

For Prescription Drug Products from a mail order In-network Pharmacy, Covered Individuals are responsible for paying the lower of:

1. The applicable Copay, or Per-Service Deductible and Coinsurance; or
2. The Prescription Drug Cost for that Prescription Drug Product.

Supply Limits – Benefits for Prescription Drug Products are subject to supply limits as written by the Physician and the supply limits that are stated above. For a single Copay or Per-service Deductible and Coinsurance, the Covered Individual may receive a Prescription Drug Product up to the stated Supply Limit.

When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 30-day supply, the Copay, or Per-service Deductible and Coinsurance, will be adjusted on a pro rata basis to number of days dispensed.

When a Prescription Drug Product is dispensed from a Mail Order Network Pharmacy, the Prescription Drug Product is subject to the supply limit stated above, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.

Some products are subject to additional supply limits based on criteria that Pharmacy Benefit Manager has developed, subject to its periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill, the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

A Covered Individual may determine whether a Prescription Drug Product has been assigned a maximum quantity level for dispensing by visiting the Student Health Plan Manager's Web Site at uky.myahpcare.com.

When a Brand-name Drug Becomes Available as a Generic – If a Generic becomes available for a Brand-name Prescription Drug Product, the Tier placement of the Brand-name Prescription Drug may change, and therefore the Copay, or Per-service Deductible and Coinsurance, may change. The Covered Individual will pay the Copay, or Per-service Deductible and Coinsurance, applicable for the Tier to which the Prescription Drug or Drug Product is assigned.

Specialty Prescription Drug Products – Benefits are provided for Specialty Prescription Drug Products. If a Covered Individual requires Specialty Prescription Drug Products, the Pharmacy Benefits Manager may direct the Covered Individual to a Designated Pharmacy with whom the Pharmacy Benefits Manager has an arrangement to provide those Specialty Prescription Drug Products. If a Covered Individual is directed to a Designated Pharmacy and chooses not to obtain their Specialty Prescription Drug Product from a

Designated Pharmacy, the benefits will be provided under the Out-of-network Prescription Drug Benefit for the Prescription Drug Product.

Specialty Prescription Drug Products Supply Limits – As written by the Physician, up to a consecutive 31 day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on Supply Limits. When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 30 day supply, the Copay, or Per-service Deductible and Coinsurance, that applies will reflect the number of days dispensed. Supply limits apply to Specialty Prescription Drug Products obtained at a Network Pharmacy, mail -order Pharmacy or a Designated Pharmacy.

Notification Requirements – Before certain Prescription Drug Products are dispensed at an In-network Pharmacy, either the Covered Individual's Physician, Covered Individual's pharmacist, or the Covered Individual is required to notify the Pharmacy Benefit Manager. The reason for notifying the Pharmacy Benefit Manager is to determine whether the Prescription Drug Product, in accordance with our approved guidelines, is each of the following:

1. It meets the definition of a Covered Medical Expense.
2. It is not an Experimental or Investigational or Unproven Service.

If the Pharmacy Benefit Manager is not notified before the Prescription Drug Product is dispensed, the Covered Individual may pay more for that Prescription Order or Refill. The Prescription Drugs requiring notification are determined by the Pharmacy Benefit Manager and are subject to periodic review and modification. The Covered Individual may determine whether a particular Prescription Drug requires notification by visiting the Student Health Plan Manager's Web Site uky.myahpcare.com for an appropriate link to the Pharmacy Benefit Manager.

If the Pharmacy Benefit Manager is not notified before the Prescription Drug Product is dispensed, the Covered Individual can ask the Pharmacy Benefit Manager to consider reimbursement after the Covered Individual receives the Prescription Drug Product. The Covered Individual will be required to pay for the Prescription Drug Product at the pharmacy. When the Covered Individual submits a claim on this basis, the Covered Individual may pay more than would have been paid if the notification requirement had been met. Benefits may not be available for the Prescription Drug Product after the Pharmacy Benefit Manager reviews the documentation provided and determines that the Prescription Drug Product is not a Covered Medical Expense or it is an Experimental or Investigational or Unproven Service.

Limitation on Selection of Pharmacies – If the Pharmacy Benefit Manager determines that a Covered Individual may be using Prescription Drug

Products in a harmful or abusive manner, or with harmful frequency, the Covered Individual's selection of In-network Pharmacies may be limited. If this happens, the Pharmacy Benefit Manager may require the Covered Individual to select a single In-network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if the Covered Individual uses the designated, single In-network Pharmacy. If the Covered Individual does not make a selection within 31 days of the date the Pharmacy Benefit Manager notifies the Covered Individual, the Pharmacy Benefit Pharmacy will select a single In-network Pharmacy for the Covered Individual.

Coverage Policies and Guidelines – The Pharmacy Benefit Manager is authorized to make Tier placement changes. The Pharmacy Benefit Manger makes the final classification of an FDA-approved Prescription Drug Product to a certain Tier by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether supply limits or notification requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Prescription Drug Product. Some Prescription Drug Products are more cost effective for specific indications as compared to others, therefore; a Prescription Drug may be listed on multiple Tiers according to the indication for which the Prescription Drug Product was prescribed. The Pharmacy Benefit Manager may periodically change the placement of a Prescription Drug Product among the Tiers. These changes may occur without prior notice to the Covered Individual.

When considering a Prescription Drug Product for Tier placement, the Pharmacy Benefit Manager reviews clinical and economic factors regarding Covered Individuals as a general population. Whether a particular Prescription Drug Product is appropriate for a Covered Individual is determined by the Covered Individual the prescribing Physician.

Additional Definitions for Prescription Drug Benefits – The following definitions are in addition to those in "III Definitions".

Brand-name means a Prescription Drug: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that the Pharmacy Benefit Manager identifies as a Brand-name product, based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. The Covered Individual should know that all products identified as a "Brand-name" by the manufacturer, pharmacy, or a Covered Individual's

Physician may not be classified as Brand-name by the Pharmacy Benefit Manager.

Chemically Equivalent means when Prescription Drug Products contain the same active ingredient.

Designated Pharmacy means a pharmacy that has entered into an agreement with the Pharmacy Benefit Manager or with an organization contracting on the Pharmacy Benefit Manager's behalf, to provide specific Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products. The fact that a pharmacy is an In-network Pharmacy does not mean that it is a Designated Pharmacy.

Experimental or Investigational Services means medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the Pharmacy Benefit Manager makes a determination regarding coverage in a particular case, are determined to be any of the following:

1) Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
2) Subject to review and approval by any institutional review board for the proposed use. Devices which are FDA approved under the H*umanitarian Use Device* exemption are not considered to be Experimental or Investigational.
3) The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions:

1) Clinical trials for which benefits are specifically covered under the Plan.
2) If the Covered Individual is not a participant in a qualifying clinical trial as specifically provided for in the Plan, and has an Injury or Illness that is likely to cause death within one year of the request for treatment the Pharmacy Benefit Manager may, in its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Medical Expense for that Injury or Illness. Prior to such a consideration, the Pharmacy Benefit Manager must first establish that there is

sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Illness or Injury.

Unproven Services means services that are not consistent with conclusions of prevailing medical research which demonstrate that the health service has a beneficial effect on health outcomes and that are not based on trials that meet either of the following designs.

1) Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
2) Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

If the Covered Individual has a life-threatening Injury or Illness (one that is likely to cause death within one year of the request for treatment) the Pharmacy Benefit Manager may, in its discretion, consider an otherwise Unproven Service to be a Covered Medical Expense for that Injury or Illness. Prior to such a consideration, the Pharmacy Benefit Manager must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Illness or Injury.

Generic means a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that the Pharmacy Benefit Manager identifies as a Generic product based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. The Covered Individual should know that all products identified as a "generic" by the manufacturer, pharmacy or Covered Individual’s Physician may not be classified as a Generic by the Pharmacy Benefit Manager.

In-network Pharmacy means a pharmacy that has:

1) Entered into an agreement with the Pharmacy Benefit Manager, or an organization contracting on behalf of the Pharmacy Benefit Manager, to provide Prescription Drug Products to Covered Individuals,
2) Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products, and

3) Been designated by the Pharmacy Benefit Manager an In-network Pharmacy.

New Prescription Drug Product means a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the U.S. Food and Drug Administration (FDA) and ending on the earlier of the following dates:

1) The date it is assigned to a Tier by the Pharmacy Benefit Manager.
2) December 31st of the following calendar year.

Prescription Drug or Prescription Drug Product means a medication, product or device that has been approved by the U.S. Food and Drug Administration and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of the benefits under the Plan, this definition includes insulin.

Prescription Drug Cost means the rate the Pharmacy Benefit Manager has agreed to pay the In-network Pharmacies, including a dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at an In-network Pharmacy.

Prescription Drug List means a list that categorizes into Tiers medications, products or devices that have been approved by the U.S. Food and Drug Administration. This list is subject to the Pharmacy Benefit Manager's periodic review and modification. The Covered Individual may determine to which Tier a particular Prescription Drug Product has been assigned by visiting the Student Health Plan Manager's Web Site at uky.myahpcare.com for a link to the Pharmacy Benefit Manager.

Specialty Prescription Drug Product means Prescription Drug Products that are generally high cost, self-injectable biotechnology drugs used to treat patients with certain illnesses. Covered Individuals may access a complete list of Specialty Prescription Drug Products by visiting the Student Health Plan Manager's Web Site at uky.myahpcare.com for a link to the Pharmacy Benefit Manager.

Therapeutically Equivalent means when Prescription Drugs can be expected to produce essentially the same therapeutic outcome and toxicity.

Usual and Customary Fee means the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Fee includes a dispensing fee and any applicable sales tax.

Additional Exclusions – In addition to the Plan Exclusions and Limitations, the following Exclusions apply:

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.

3. Experimental or Investigational Services or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by the Pharmacy Benefit Manager to be experimental, investigational or unproven.

4. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that the Pharmacy Benefit Manager determines do not meet the definition of a Covered Medical Expense.

5. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a Tier by the Pharmacy Benefit Manager.

6. Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a Prescription Order or Refill. Compounded drugs that are available as a similar commercially available Prescription Drug Product. Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier-3.

7. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Pharmacy Benefit Manager has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that the Pharmacy Benefit Manager has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the Pharmacy Benefit Manager may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

8. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Illness or Injury, except as specifically provided in the Plan.

9. A Prescription Drug Product that contains an active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product.

10. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product.

D. Benefits for other services, supplies, and providers include:
   1. Ambulance Services
   2. Durable Medical Equipment – Durable medical equipment must be all of the following:
      a. Provided or prescribed by a Physician. A prescription must accompany the claim when submitted.
      b. Primarily and customarily used to serve a medical purpose.
      c. Can withstand repeated use.
      d. Generally is not useful to a person in the absence of Injury or Illness.
      e. Not consumable or disposable except as needed for the effective use of covered durable medical equipment.

      For the purposes of this benefit, the following are considered durable medical equipment:
      f. Braces that stabilize an injured body part and braces to treat curvature of the spine.
      g. External prosthetic devices that replace a limb or body part but does not include any device that is fully implanted into the body.
      h. Orthotic devices that straighten or change the shape of a body part.
   3. If more than one piece of equipment or device can meet the Covered Individual's functional needs, benefits are available only for the equipment or device that meets the minimum specifications for the Covered Individual's needs. Dental braces are not durable medical equipment and are not covered. Benefits for durable medical equipment are limited to the initial purchase or one replacement purchase per Plan Year. No benefits will be paid for rental charges in excess of purchase price.
   4. Consultant Physician Fees – Includes services provided on an Inpatient or outpatient basis.
   5. Dental Treatment – Benefits will be paid only for services to restore Sound, Natural Teeth after an Injury. Breaking a tooth while eating is not covered. Routine dental care and treatment to the gums are not covered. This benefit is separate from the Pediatric Dental Benefits covered under this Plan. Benefits will also be provided the same as any other Illness for the Hospital or facility charges and anesthesia services performed in a Hospital in connection with dental procedures for the following:
      a. A Covered Individual under the age of 9.

b. A Covered Individual with serious mental or physical conditions.
c. A Covered Individual with significant behavioral problems.
d. A Covered Individual whose medical condition or dental procedure requires a Hospital setting to ensure the Covered Individual's safety. This does not include benefits for the dental procedure.

6. Mental Illness Treatment – Benefits will be paid the same as any other Illness for services received on an Inpatient basis while confined to a Hospital including partial hospitalization or day treatment received at a Hospital, and on an outpatient basis including intensive outpatient treatment. Institutions specializing in, or primarily treating, Mental Illness and Substance Use Disorders are not covered.
7. Substance Use Disorder Treatment – Institutions specializing in or primarily treating Mental Illness and Substance Use Disorders are not covered. Benefits will be paid the same as any other Illness for services received on an Inpatient basis while confined to a Hospital including partial hospitalization or day treatment received at a Hospital, and on an outpatient basis including intensive outpatient treatment.

   Two (2) Inpatient and two (2) Outpatient substance abuse rehabilitation programs are allowed per Covered Individual per lifetime.

8. Maternity – Office visits for prenatal care are covered at 100% after the initial visit when services are rendered at a Preferred Provider or In-network Provider. Other maternity care is treated the same as any other Illness. Benefits will be paid for an Inpatient stay of at least 48 hours following a vaginal delivery, and 96 hours following a cesarean section delivery. If the mother agrees, the attending Physician may discharge the mother earlier than these minimum time frames.
9. Complications of Pregnancy
10. Preventive Care Services – Covered at 100% and no Deductible, Copays or Coinsurance will be applied when the services are received from a Preferred Provider. Preventive Care Services covered under the Plan include medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and are limited to the following as required under applicable law:
    a. Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force.
    b. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

c. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
d. With respect to women, such additional preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

11. Reconstructive Breast Surgery Following Mastectomy – Covered the same as any other Illness after, and in connection with, a covered mastectomy. Benefits include a) All stages of reconstruction of the breast on which the mastectomy has been performed, b) Surgery and reconstruction of the other breast to produce a symmetrical appearance, and c) prostheses and physical complications of mastectomy, including lymphedemas.
12. Diabetes Services – Benefits will be paid for Medically Necessary:
    a. Outpatient self-management training, education and medical nutrition therapy service when ordered by a Physician and provided by appropriately licensed or registered healthcare professionals.
    b. Prescription Drugs, equipment, and supplies including insulin pumps and supplies, blood glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices.
13. Home Health Care – Benefits are limited to 100 visits maximum per Plan Year. Each visit by an authorized representative of a home health agency shall be considered as one (1) home health care visit except that at least four (4) hours of home health aide service shall be considered as one (1) home health visit.

    Home health care shall not be reimbursed unless an attending Physician certifies that hospitalization or confinement in a Skilled Nursing Facility as defined by the Kentucky health facilities and health services certificate of need and licensure board would otherwise be required if home health care was not provided.

    Benefits shall also include an additional 250 maximum visits for Private Duty Nursing. For the purposes of this benefit “private duty nursing” means skilled nursing service provided on a one-to-one basis by an actively practicing Registered Nurse (R.N.) or licensed practical nurse (L.P.N). Private duty nursing is shift nursing of eight (8) hours or greater per day and does not include nursing care of less than eight (8) hours per day. Private duty nursing does not include Custodial Care service.

    Medicare beneficiaries shall be deemed eligible to receive home health care benefits under this Plan provided that the Plan shall only pay for

those home health care services which are not paid for by Medicare and do not exceed the maximum liability of the Plan.

Benefits shall be subject to all Deductible, Copay, Coinsurance, limitations, or any other provisions of the Plan.

14. Hospice Care – Covered when recommended by a Physician for a Covered Individual who is terminally ill, and the Physician has determined the Covered Individual has a life expectancy of six months or less. All hospice care must be received from a licensed hospice agency. Hospice care includes:
    a. Physical, psychological, social, and spiritual care for the terminally ill Covered Individual.
    b. Short-term grief counseling for immediate family members while the Covered Individual is receiving hospice care.
15. Inpatient Rehabilitation Facility – Services received while confined as a full-time Inpatient in a licensed Inpatient Rehabilitation Facility. Confinement in the Inpatient Rehabilitation Facility must follow within 24 hours of, and be for the same or related cause(s) as, a period of Hospital Confinement or Skilled Nursing Facility confinement. Benefits include a day rehabilitation therapy program for Covered Individuals who do not require Inpatient care but still require a rehabilitation therapy program four to eight hours a day 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 Medical Expense.
16. Skilled Nursing Facility – Services received while confined as an Inpatient in a Skilled Nursing Facility for treatment rendered for one of the following:
    a. In lieu of Hospital Confinement as a full-time inpatient.
    b. Within 24 hours following a Hospital Confinement and for the same or related cause(s) as such Hospital Confinement.
17. Urgent Care Center – Benefits are limited to the facility or clinic fee billed by the Urgent Care Center. All other services rendered during the visit will be subject to any applicable Deductible, Per-service Deductible, Copay, or Coinsurance.
18. Approved Clinical Trials – Routine patient care costs incurred during participation in an Approved Clinical Trial for the treatment of cancer or other Life-threatening Condition. The Covered Individual must be clinically eligible for participation in the Approved Clinical Trial according to the trial protocol and either: 1) the referring Physician is a participating health care provider in the trial and has concluded that the Covered Individual's participation would be appropriate; or 2) the Covered Individual provides medical and scientific evidence information establishing that the Covered

Individual's participation would be appropriate. "Routine patient care costs" means Covered Medical Expenses which are typically provided absent a clinical trial and not otherwise excluded under the Plan. Routine patient care costs do not include:

a. The experimental or investigational item, device or service, itself.
b. Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
c. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

"Life-threatening condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

"Approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following:

d. Federally funded trials that meet required conditions.
e. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
f. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

19. Organ Transplantation Services – Treated the same as any other Illness for organ or tissue transplants when ordered by a Physician. Benefits are available when the transplant meets the definition of a Covered Medical Expense. Donor costs, including one (1) unrelated donor search per Plan Year, including that are directly related to organ removal are Covered Medical Expenses for which benefits are payable through the Covered Individual organ recipient's coverage under this Plan. Benefits payable for the donor will be secondary to any other insurance plan, service plan, self-funded group plan, or any government plan that does not require this Plan to be primary. No benefits are payable for transplants which are considered an Elective Surgery or Elective Treatment and transplants involving permanent mechanical or animal organs.

    Travel expenses are for transportation and lodging are covered and limited to $10,000 per transplant benefit paid. The Plan will provide assistance with reasonable and necessary travel expenses when Covered Individual is required to travel more than 75 miles from residence to reach the facility where the covered transplant procedure will be performed. Assistance with travel expenses includes transportation to and from the

facility and lodging for the patient and one companion. If the Covered Individual is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions.

Health services connected with the removal of an organ or tissue from a Covered Individual for purposes of a transplant to another person are not covered.

20. Pediatric Dental and Vision Services – Refer to the “Pediatric Dental Benefits” and “Pediatric Vision Benefits” sections of this document for details.
21. Hearing Aids – Hearing aids for Covered Individuals when required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver. Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. If more than one type of hearing aid can meet the Covered Individual’s functional needs, benefits are available only for the hearing aid that meets the minimum specifications for the Covered Individual’s needs. Benefits are limited to one hearing aid per hearing impaired ear every 36 months.
22. Medical Foods – Benefits are payable for therapeutic food, formulas, supplements, and low-protein modified food products for the treatment of inborn errors of metabolism or genetic conditions. Medical foods must be prescribed by a Physician. The prescription must accompany the claim when submitted.
23. Medical Supplies – Medical supplies must be prescribed by a Physician (a written prescription must accompany the claim when submitted) and used for the treatment of a covered Injury or Illness. Benefits are limited to a 31-day supply per purchase.
24. Ostomy Supplies – Benefits for ostomy supplies are limited to the following supplies:
    a. Pouches, face plates and belts.
    b. Irrigation sleeves, bags and ostomy irrigation catheters.
    c. Skin barriers.
25. Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.
26. Wigs – Wigs and other scalp hair prostheses as a result of hair loss due to cancer treatment are covered. Benefits are limited to one wig or prosthesis per Plan Year.
27. Mammography – Benefits will be paid the same as any other Illness for low-dose mammography screening according to the following guidelines:

a. One screening mammogram to women age thirty-five through thirty-nine.
b. One mammogram every 2 years for women age forty of age and older.
c. One mammogram per year for women age 50 and older.

Benefits shall also provide coverage for mammograms, performed on dedicated equipment that meets the guidelines established by the American College of Radiology, for any Covered Individual, regardless of age, who has been diagnosed with breast disease upon referral by a health care practitioner acting within the scope of his or her licensure.

“Mammography" means an x-ray examination of the breast using equipment dedicated specifically for mammography, including, but not limited to, the x-ray tube, filter, compression device, screens, film and cassettes, with two views of each breast and with an average radiation exposure at the current recommended level as set forth in guidelines of the American College of Radiology.

Benefits shall be subject to all Deductible, Copay, Coinsurance, limitations, or any other provisions of the Plan.

28. Educational Exposure to Blood Borne Pathogen Benefit - This benefit covers 100% of Physician prescribed medication from the first day of the exposure through the twenty-eight (28) day after the exposure. This benefit is not part of the prescription drug benefit, but is part of the medical plan. The Covered Individual is required to pay for the prescribed medication in full and submit claims to the Claims Administrator for reimbursement under the Plan.
29. Bone Marrow Transplant for Treatment of Breast Cancer – Benefits will be paid the same as any other Illness for the treatment of breast cancer by high-dose chemotherapy with autologous bone marrow transplantation or stem cell transplantation. The administration of high-dose chemotherapy with autologous bone marrow transplantation or stem cell transplantation shall only be covered when performed in an institution that complies with the guidelines of the American Society for Blood and Marrow transplantation or the International Society of Hematotherapy and Graft Engineering, whichever has the higher standard. Benefits shall be subject to all Deductible, Copay, Coinsurance, limitations, or any other provisions of the Plan.
30. Temporomandibular Joint Disorder and Craniomandibular Disorder – Benefits will be paid the same as for treatment to any other joint in the body, for surgical and non-surgical treatment of temporomandibular joint disorder and craniomandibular jaw disorder. Treatment may be administered or prescribed by a Physician or dentist. Benefits shall be

subject to all Deductible, Copay, Coinsurance, limitations, or any other provisions of the Plan.

31. Bone Density Testing for Osteoporosis Detection – Benefits will be paid the same as any other Illness for bone density testing for women age thirty-five (35) and older, as indicated by the Physician, in accordance with standard medical practice, to obtain baseline data for the purpose of early detection of osteoporosis. Benefits shall be subject to all Deductible, Copay, Coinsurance, limitations, or any other provisions of the Plan.
32. Non-emergency care when traveling outside the United States.
33. Routine eye exams for adults – benefits for routine eye exam and refraction only. Services for vision training and orthoptics, and eyeglasses and eyewear, are not covered.
34. Chiropractic Services – Benefits include spinal manipulation and manual medical intervention services. Benefits are limited to twelve (12) visits per Plan Year.
35. Renal Dialysis and Hemodialysis
36. Allergy Treatment
37. Biofeedback – When Medically Necessary and ordered by a Physician.
38. Vision correction after surgery or accident – Prescription glasses or contact lenses when required as a result of surgery or for the treatment of an accidental Injury.

V. Pediatric Dental Services Benefits

Benefits are provided under this Plan for Covered Dental Services, as described below, for Covered Individuals under the age of 21. Benefits under this Plan terminate on the earlier of: 1) date the Covered Individual reaches the age of 21; or 2) the date the Covered Individual's coverage under the Plan terminates.

Section 1: Accessing Pediatric Dental Services

Pediatric Dental benefits are available when the Covered Individual chooses to obtain Covered Dental Services directly from a UK HealthCare Provider.

Covered Individuals must always verify the participation status of a provider prior to seeking services. From time to time, the participation status of a provider may change. Participation status can be verified by visiting the Student Health Plan Manger's Web Site at uky.myahpcare.com for a link to In-network Dentists.

The Plan will not pay for Pediatric Dental services obtained from any provider other than UK HealthCare providers.

Covered Dental Services

Plan Benefits will be paid for Covered Dental Services listed in the Plan if such Dental Services are Necessary and are provided by or under the direction of a UK HealthCare Provider.

Benefits are available only for Necessary Dental Services. The fact that a Dental Provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a dental disease, does not mean that the procedure or treatment is a Covered Dental Service under this Plan.

Pre-Treatment Estimate – If the charge for a Dental Service is expected to exceed $300 or if a dental exam reveals the need for fixed bridgework, the Covered Individual may notify the Claims Administrator of such treatment before treatment begins and receive a pre-treatment estimate. To receive a pre-treatment estimate, the Covered Individual or Dental Provider should send a notice to the Claims Administrator, via claim form, within 20 calendar days of the exam. If requested, the Dental Provider must provide the Claims Administrator with dental x-rays, study models or other information necessary to evaluate the treatment plan for purposes of benefit determination.

The Claims Administrator will determine if the proposed treatment is a Covered Dental Service and will estimate the amount of payment. The estimate of benefits payable will be sent to the Dental Provider and will be subject to all terms, conditions and provisions of the Plan. Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be assigned a benefit based on the less costly procedure.

A pre-treatment estimate of benefits is not an agreement to pay for expenses. This procedure lets the Covered Individual know in advance approximately what portion of the expenses will be considered for payment.

Pre-Authorization – Pre-authorization is required for all orthodontic services. The Covered Individual should speak to the Dental Provider about obtaining a pre-authorization before Dental Services are rendered. If the Covered Individual does not obtain a pre- authorization, the claim may be denied for failure to comply with this requirement.

If a treatment plan is not submitted, the Covered Individual will be responsible for payment of any dental treatment not approved by the Claims Administrator. Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be assigned a benefit based on the less costly procedure.

Section 2: Benefits for Pediatric Dental Services

Benefits are provided for the Dental Services stated in this section when such services are:

A. Necessary.
B. Provided by or under the direction of a Dental Provider.
C. Clinical situations that can be effectively treated by a less costly, dental appropriate alternative procedure will be assigned a Benefit based on the least costly procedure.
D. Not excluded under this Plan as described in the Pediatric Dental Services Exclusions and Limitations. Benefits for Covered Dental Services are subject to satisfaction of the Dental Services Deductible.

Dental Services Deductible – Benefits for Pediatric Dental Services provided under this Plan are not subject to the Deductible specified in the Medical and Prescription Drugs Benefits section of this document. Instead, benefits for pediatric Dental Services are subject to a separate Dental Services Deductible. For any combination of In-network and Out-of-network Benefits, the Dental Services Deductible per Plan Year is $500 per Covered Individual.

Any amount the Covered Individual pays in Deductibles for Dental Care Services under this Plan applies to the Out-of-Pocket Maximum stated in the Medical and Prescription Drug Benefits section of this document.

Dental Services Deductibles are calculated on a Plan Year basis.

Benefit limits are calculated on a Plan Year basis unless otherwise specifically stated.

Benefits for the following Dental Services are paid at 50% of the Eligible Dental Expenses, subject to any limitations indicated:

1. Diagnostic Services
    a. Intraoral Bitewing Radiographs (Bitewing X-ray) – Limited to 1 set of films every 6 months.
    b. Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) – Limited to 1 film every 24 months.
    c. Periodic Oral Evaluation (Checkup Exam) – Limited to 1 every 6 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.
2. Preventive Services
    a. Dental Prophylaxis (Cleanings) – Limited to 1 every 6 months.
    b. Fluoride Treatments – Limited to 2 treatments per 12 months. Treatment should be done in conjunction with dental prophylaxis.
    c. Sealants (Protective Coating) – Limited to one sealant per tooth every 36 months.
3. Space Maintainers
    a. Space Maintainers – Limited to two per 12 months. Benefit includes all adjustments within 6 months of installation.

4. Minor Restorative Services, Endodontics, Periodontics and Oral Surgery
    a. Amalgam Restorations (Silver Fillings) – Multiple restorations on one surface will be treated as a single filling.
    b. Composite Resin Restorations (Tooth Colored Fillings) – For anterior (front) teeth only.
    c. Periodontal Surgery (Gum Surgery) – Limited to one quadrant or site per 36 months per surgical area.
    d. Scaling and Root Planing (Deep Cleanings) – Limited to once per quadrant per 12 months.
    e. Periodontal Maintenance (Gum Maintenance) – Limited to 4 times per 12 month period following active and adjunctive periodontal therapy, within the prior 24 months, exclusive of gross debridement.
    f. Endodontics (root canal therapy) – performed on anterior teeth, bicuspids, and molars and Endodontic Surgery
    g. Simple Extractions (Simple tooth removal) – Limited to 1 time per tooth per lifetime.
    h. Oral Surgery, including Surgical Extraction
5. Adjunctive Services
    a. General Services (including Emergency Treatment of dental pain) – Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary.
    b. Occlusal guards for Covered Individuals age 13 and older – Limited to one guard every 12 months.
6. Major Restorative Services
    a. Inlays/Onlays/Crowns (Partial to Full Crowns) – Limited to once per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.
    b. Fixed Prosthetics (Bridges) – Limited to once per tooth per 60 months. Covered only when a filling cannot restore the tooth.
    c. Removable Prosthetics (Full or partial dentures) – Limited to one per consecutive 60 months. No additional allowances for precision or semi-precision attachments.
    d. Denture Repair – Limited to 3 repairs of resin denture base or repair of cast framework per 12 months. Limited to replacement of broken tooth on a denture, laboratory relining of maxillary or mandibular denture, and interim maxillary or mandibular partial denture once per 12 months.
    e. Repairs or Adjustments to Bridges or Crowns – Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to one per 24 months.
7. Implants
    a. Implant Placement – Limited to once per 60 months.

b. Implant Supported Prosthetics – Limited to once per 60 months.
c. Implant Maintenance Procedures – Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to once per 60 months.
d. Repair Implant Supported Prosthesis by Report – Limited to once per 60 months.
e. Abutment Supported Crown (Titanium) or Retainer Crown for FPD – Titanium – Limited to once per 60 months.
f. Repair Implant Abutment by Support – Limited to once per 60 months.
g. Radiographic/Surgical Implant Index by Report – Limited to once per 60 months.

8. Medically Necessary Orthodontics

   Benefits for comprehensive orthodontic treatment are approved by the Claims Administrator, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crouzon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by the Claims Administrator's dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized.

   a. Orthodontic Services – Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.

Section 3: Pediatric Dental Services Exclusions and Limitations

The following Pediatric Dental Exclusions and Limitations are in addition to those listed in the Exclusions and Limitations of the Plan. Except as may be specifically provided under Section 2: Benefits for Covered Dental Services, benefits are not provided under this Plan for the following:

1. Any Dental Service or Procedure not listed as a Covered Dental Service under the Plan.
2. Dental Services that are not Necessary.
3. Hospitalization or other facility charges.
4. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)

5. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, Injury, or Congenital Condition, when the primary purpose is to improve physiological functioning of the involved part of the body.
6. Any Dental Procedure not directly associated with dental disease.
7. Any Dental Procedure not performed in a dental setting.
8. Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.
9. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
10. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
11. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Conditions of hard or soft tissue, including excision.
12. Replacement of complete dentures, fixed and removable partial dentures or crowns and implants, implant crowns and prosthesis if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non -compliance, the patient is liable for the cost of replacement.
13. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including surgery related to the temporomandibular joint). Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint.
14. Charges for failure to keep a scheduled appointment without giving the dental office at least a 24 hour notice.
15. Expenses for Dental Procedures begun prior to the Covered Individual's Effective Date of coverage.
16. Dental Services otherwise covered under the Plan, but rendered after the date individual coverage under the Plan terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Plan terminates.
17. Services rendered by a provider with the same legal residence as the Covered Individual or who is a member of the Covered Individual's family, including spouse, brother, sister, parent or child.
18. Foreign Services are not covered unless required for a Dental Emergency.

19. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
20. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
21. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
22. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
23. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
24. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
25. Maxillofacial prosthetic services, except for the following when provided by a board certified prosthodontist:
    a. A nasal prosthesis
    b. An auricular prosthesis
    c. A facial prosthesis
    d. A mandibular resection prosthesis
    e. A pediatric speech aid
    f. An adult speech aid
    g. A palatal augmentation prosthesis
    h. A palatal lift prosthesis
    i. An oral surgical splint
    j. An unspecified maxillofacial prosthetic.

Section 4: Defined Terms for Pediatric Dental Services

The following definitions are in addition to those listed in “III Definitions”.

Covered Dental Service – a Dental Service or Dental Procedure for which benefits are provided under this Plan.

Dental Emergency - a dental condition or symptom resulting from dental disease which arises suddenly and, in the judgment of a reasonable person, requires immediate care and treatment, and such treatment is sought or received within 24 hours of onset.

Dental Provider - any UK HealthCare dentist or dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to render Dental Services, perform dental surgery or administer anesthetics for dental surgery.

Dental Service or Dental Procedures - dental care or treatment provided by a Dental Provider to the Covered Individual while the Plan is in effect, provided such care or treatment is recognized by the Claims Administrator as a generally accepted form of care or treatment according to prevailing standards of dental practice.

Dental Services Deductible - the amount the Covered Individual must pay for Covered Dental Services in a Plan Year before the Claims Administrator will begin paying benefits in that Plan Year.

Eligible Dental Expenses - Eligible Dental Expenses for Covered Dental Services, incurred while the Plan is in effect, are based on the billed charges or contracted fees of UK HealthCare Providers.

Experimental, Investigational, or Unproven Service - medical, dental, surgical, diagnostic, or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the Claims Administrator makes a determination regarding coverage in a particular case, is determined to be:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use; or
- Subject to review and approval by any institutional review board for the proposed use; or
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2, or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or
- Not determined through prevailing peer-reviewed professional literature to be safe and effective for treating or diagnosing the condition or Illness for which its use is proposed.

Foreign Services - services provided outside the U.S. and U.S. Territories.

Necessary - Dental Services and supplies under this Plan which are determined by the Claims Administrator through case-by-case assessments of care based on accepted dental practices to be appropriate and are all of the following:

- Necessary to meet the basic dental needs of the Covered Individual.
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Service.
- Consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are typically accepted by the similar plans administrated by the Claims Administrator.

- Consistent with the diagnosis of the condition.
- Required for reasons other than the convenience of the Covered Individual or his or her Dental Provider.
- Demonstrated through prevailing peer-reviewed dental literature to be either:
- Safe and effective for treating or diagnosing the condition or illness for which their use is proposed; or
- Safe with promising efficacy:
    - For treating a life threatening dental disease or condition.
    - Provided in a clinically controlled research setting.
    - Using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health. (For the purpose of this definition, the term life threatening is used to describe dental diseases or illnesses or conditions, which are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a Dental Provider has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular dental disease does not mean that it is a Necessary Covered Dental Service as defined in this Plan. The definition of Necessary used in this Plan relates only to benefits under this Plan and differs from the way in which a Dental Provider engaged in the practice of dentistry may define necessary.

VI. Pediatric Vision Care Services

Benefits are provided under the Plan Vision Care Services, as described below, for Covered Individuals under the age of 21. Benefits under the Plan terminate on the earlier of: 1) date the Covered Individual reaches the age of 21; or 2) the date the Covered Individual's coverage under the Plan terminates.

Section 1: Benefits for Pediatric Vision Care Services

Benefits are available for Pediatric Vision Care Services only from UK HealthCare Providers. When obtaining these Vision Care Services, the Covered Individual will be required to pay any Copays at the time of service.

Out-of-Pocket Maximum - any amount the Covered Individual pays in Coinsurance or Copays for Vision Care Services under the Plan applies toward satisfaction of the Out-of-Pocket Maximum stated in Medical and Prescription Drug Benefits.

Plan Deductible – Benefits for pediatric Vision Care Services provided under the Plan are not subject to any Plan Deductible stated in the Plan Schedule of Benefits. Any amount the Covered individual pays in Copays for Vision Care

Services under the Plan does not apply to the Plan Deductible stated in the Plan Schedule of Benefits.

Benefit Limits – Benefit limits are calculated on a Plan Year basis unless otherwise specifically stated.

Frequency of Service Limits – Benefits are provided for the Vision Care Services described below, subject to Frequency of Service limits and Copays and Coinsurance stated under each Vision Care Service.

1. Routine Vision Examination – A routine vision examination of the condition of the eyes and principal vision functions according to the standards of care in the jurisdiction in which the Covered individual resides, including:
    a. A case history that includes chief complaint and/or reason for examination, patient medical/eye history, and current medications.
    b. Recording of monocular and binocular visual acuity, far and near, with and without present correction (for example, 20/20 and 20/40).
    c. Cover test at 20 feet and 16 inches (checks eye alignment).
    d. Ocular motility including versions (how well eyes track) near point convergence (how well eyes move together for near vision tasks, such as reading), and depth perception.
    e. Pupil responses (neurological integrity).
    f. External exam.
    g. Retinoscopy (when applicable) – objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.
    h. Phorometry/Binocular testing – far and near: how well eyes work as a team.
    i. Tests of accommodation and/or near point refraction: how well the Covered Individual sees at near point (for example, reading).
    j. Tonometry, when indicated: test pressure in eye (glaucoma check).
    k. Ophthalmoscopic examination of the internal eye.
    l. Confrontation visual fields.
    m. Biomicroscopy.
    n. Color vision testing.
    o. Diagnosis/prognosis.
    p. Specific recommendations.

    Post examination procedures will be performed only when materials are required.

Or, in lieu of a complete exam, Retinoscopy (when applicable) - objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.

2. Eyeglass Lenses – Lenses that are mounted in eyeglass frames and worn on the face to correct visual acuity limitations.

   The Covered Individual is eligible to select only one of either eyeglasses (Eyeglass Lenses and/or Eyeglass Frames) or Contact Lenses. If the Covered Individual selects more than one of these Vision Care Services, the Plan will pay Benefits for only one Vision Care Service.

   The following Optional Lens Extras are covered in full:

   a. Standard scratch-resistant coating.
   b. Polycarbonate lenses.

3. Eyeglass Frames – A structure that contains eyeglass lenses, holding the lenses in front of the eyes and supported by the bridge of the nose. The Covered Individual is eligible to select only one of either eyeglasses (Eyeglass Lenses and/or Eyeglass Frames) or Contact Lenses. If the Covered Individual selects more than one of these Vision Care Services, the Plan will pay Benefits for only one Vision Care Service.

   Replacement of up to one complete pair of eyeglasses per Plan year if necessary as determined by the Vision Care Provider and subject to the Vision Care Services Schedule of Benefits. Eyeglasses consist of either eyeglass lenses, eyeglass frames, or both eyeglass lenses and frames.

4. Contact Lenses – Lenses worn on the surface of the eye to correct visual acuity limitations. Benefits include the fitting/evaluation fees and contacts.

   The Covered Individual is eligible to select only one of either eyeglasses (Eyeglass Lenses and/or Eyeglass Frames) or Contact Lenses. If the Covered Individual selects more than one of these Vision Care Services, the Plan will pay Benefits for only one Vision Care Service.

5. Necessary Contact Lenses – Benefits are available when a Vision Care Provider has determined a need for and has prescribed the contact lens. Such determination will be made by the Vision Care Provider and not by the Plan.

   Contact lenses are necessary if the Covered individual has any of the following:

   a. Keratoconus.
   b. Anisometropia.
   c. Irregular corneal/astigmatism
   d. Aphakia.

e. Facial deformity.
f. Corneal deformity.

Copays, Limits, and Coinsurance:

Vision Care Service	Frequency of Service	Network Benefit	Out-of-network Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	100% after a Copay of $20.	No Benefit
Eyeglass Lenses	Once per year.		
Single Vision		100% after a Copay of $40.	No Benefit
Bifocal		100% after a Copay of $40.	No Benefit
Trifocal		100% after a Copay of $40.	No Benefit
Lenticular		100% after a Copay of $40.	No Benefit
Eyeglass Frames	Once per year.		No Benefit
Eyeglass frames with a retail cost up to $130.		100%	No Benefit
Eyeglass frames with a retail cost of $130 - 160.		100% after a Copay of $15.	No Benefit
Eyeglass frames with a retail cost of $160 - 200.		100% after a Copay of $30.	No Benefit
Eyeglass frames with a retail cost of $200 - 250.		100% after a Copay of $50.	No Benefit
Eyeglass frames with a retail cost greater than $250.		60%	No Benefit
Contact Lenses	Limited to a 12 month supply.		No Benefit
Covered Contact Lens Selection		100% after a Copay of $40.	No Benefit
Necessary Contact Lenses		100% after a Copay of $40.	No Benefit

Section 2: Pediatric Vision Exclusions

The following Exclusions are in addition to those listed in Exclusions and Limitations.

Except as may be specifically provided under Benefits for Pediatric Vision Care Services, benefits are not provided for the following:

1. Medical or surgical treatment for eye disease which requires the services of a Physician and for which benefits are available as stated in the Plan.
2. Non-prescription items (e.g. Plano lenses).
3. Replacement or repair of lenses and/or frames that have been lost or broken, except as specifically provided in the Eyeglass Replacement provision.
4. Optional Lens Extras not listed in Section 1: Benefits for Vision Care Services.
5. Missed appointment charges.
6. Applicable sales tax charged on Vision Care Services.

Section 3: Defined Terms for Pediatric Vision Care Services

The following definitions are in addition to those listed in Definitions:

Covered Contact Lens Selection – a selection of available contact lenses that may be obtained from a UK HealthCare Vision Care Provider on a covered-in-full basis, subject to payment of any applicable Copay.

Vision Care Provider - any optometrist, ophthalmologist, optician or other person who may lawfully provide Vision Care Services.

Vision Care Service - any service or item listed in this for Pediatric Vision Care Services section.

VII. Exclusions and Limitations

Nothing in this Exclusions and Limitations section shall be interpreted as excluding Essential Health Benefits.

No benefits will be paid for a) loss or expense caused by, contributed to, or resulting from; or b) treatment, services or supplies for, at, or related to any of the following:

1. Acupuncture.
2. Cosmetic procedures, except reconstructive procedures, to:
    a. Correct an Injury or treat an Illness for which benefits are otherwise payable under this Plan. The primary result of the procedure is not a changed or improved physical appearance.
    b. Treat or correct Congenital Conditions of a Newborn or adopted Infant.
    c. Correct hemangiomas and port wine stains of the head and neck areas for Covered Individuals 18 years of age or younger .
    d. Correct limb deformities such as club hand, club foot, syndactyly, polydactyly, or macrodactylia.
    e. Improve hearing by directing sound in the ear canal by performing Otoplasty, when ear or ears are absent or deformed from Injury, surgery, disease, or Congenital Condition.
    f. Correct diagnosis of tongue-tied by performing tongue release.
    g. Treat or correct Congenital Conditions causing skull deformity such as Crouzon's disease.
    h. Correct cleft lip and cleft palate.
3. Custodial Care.
    a. Care provided in: rest homes, health resorts, homes for the aged, halfway houses, college infirmaries or places mainly for domiciliary or Custodial Care.
    b. Extended care in treatment or substance abuse facilities for domiciliary or Custodial Care.
4. Dental treatment, except:
    a. For accidental Injury to Sound, Natural Teeth.
    b. As described under Dental Treatment in the Plan.
    c. Benefits specifically provided under Pediatric Dental Services Benefits.
5. Elective Surgery or Elective Treatment.
6. Flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline; or chartered aircraft only while participating in a school sponsored intercollegiate sport.
7. Foot care for the following:
    a. Flat foot conditions.
    b. Supportive devices for the foot.
    c. Subluxations of the foot.

d. Fallen arches.
e. Weak feet.
f. Chronic foot strain.
g. Routine foot care including the care, cutting and removal of corns, calluses, toenails, and bunions (except capsular or bone surgery).

This exclusion does not apply to preventive foot care for Covered Individuals with diabetes.

8. Health spa or similar facilities. Strengthening programs.
9. Hearing examinations. Hearing aids. Other treatment for hearing defects and hearing loss. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process. This exclusion does not apply to:
    a. Hearing defects or hearing loss as a result of an Illness or Injury.
    b. Benefits specifically provided in the Plan.
10. Hypnosis.
11. Immunizations, except as specifically provided in the Plan. Preventive medicines or vaccines, except where required for treatment of a covered Injury or as specifically provided in the Plan.
12. Injury or Illness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation.
13. Injury sustained while:
    a. Participating in any intercollegiate or professional sport, contest or competition.
    b. Traveling to or from such sport, contest or competition as a participant.
    c. Participating in any practice or conditioning program for such sport, contest or competition.
14. Investigational services.
15. Marital or family counseling.
16. Commission of or attempt to commit a felony.
17. Prescription Drugs, services or supplies as follows:
    a. Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non -medical substances, regardless of intended use, except as specifically provided in the Plan.
    b. Immunization agents, except as specifically provided in the Plan. Biological sera. Blood or blood products administered on an outpatient basis.
    c. Drugs labeled, “Caution - limited by federal law to investigational use” or experimental drugs.
    d. Products used for cosmetic purposes.
    e. Drugs used to treat or cure baldness. Anabolic steroids used for body building.
    f. Anorectics - drugs used for the purpose of weight control.

g. Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra.
h. Growth hormones, except for children born small for gestational age.
i. Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.

18. Reproductive/Infertility services including the following:
    a. Procreative counseling.
    b. Genetic counseling and genetic testing.
    c. Cryopreservation of reproductive materials. Storage of reproductive materials.
    d. Fertility tests.
    e. Infertility treatment (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception.
    f. Premarital examinations.
    g. Impotence, organic or otherwise.
    h. Reversal of sterilization procedures.
    i. Sexual reassignment surgery.
19. Research or examinations relating to research studies, or any treatment for which the patient or the patient's representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research study or clinical research study, except as specifically provided in the Plan.
20. Routine eye examinations. Eye refractions. Eyeglasses. Contact lenses. Prescriptions or fitting of eyeglasses or contact lenses. Vision correction surgery. Treatment for visual defects and problems. This exclusion does not apply: 1) when due to a covered Injury or Illness, 2) to benefits specifically provided under Pediatric Vision Services, and 3) to one pair of eyeglasses or contact lenses following intraocular lens implantation to treat cataracts or aphakia, or 4) to benefits specifically provided under the Plan.
21. Routine Newborn Infant Care and well-baby nursery and related Physician charge, except as specifically provided in the Plan.
22. Preventive care services, except as specifically provided in the Plan, including:
    a. Routine physical examinations and routine testing.
    b. Preventive testing or treatment.
    c. Screening exams or testing in the absence of Injury or Illness.
23. Services provided normally without charge by the Health Service of the Covered Individual.
24. Nasal and sinus surgery, except for treatment of a covered Injury or treatment of chronic sinusitis.
25. Sleep disorders.
26. Supplies, except as specifically provided in the Plan.
27. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia, except as specifically provided in the Plan.

28. Treatment in a Government hospital, unless there is a legal obligation for the Covered Individual to pay for such treatment.
29. Charges for Illness or Injury from any war or any act of war, declared or undeclared; or while in the armed forces of any country.
30. Charges for weight management, weight reduction, nutrition programs, treatment for obesity, or surgery for removal of excess skin or fat.

VIII. Coordination of Benefits and Subrogation

When a Covered Individual is covered under this Plan and one or more other plans or insurance policies that provide benefits for the same Covered Medical Expenses, the Claims Administrator will coordinate the payment of benefits payable under this Plan with the other plan or insurance policy. The Claims Administrator will follow rules for the Coordination of Benefits (COB) that are typically followed by other claims administrators and insurance companies. In no event will the benefits payable under this Plan exceed Covered Medical Expenses. For details about COB, visit the Student Health Plan Manager's Web Site at uky.myahpcare.com.

The Plan shall be subrogated to all rights of recovery which any Covered Individual has against any person, firm or corporation to the extent of payments for benefits made by the Plan to or for benefit of a Covered Individual. The Covered Individual shall execute and deliver such instruments and papers as may be required and do whatever else is necessary to secure such rights to the Plan.

IX. Appeals Process

For the purpose of this Notice, the following terms are defined as shown below:

Adverse Determination means 1) A determination by the Claims Administrator or Pharmacy Benefits Manager that, based upon the information provided, a request for benefits under the Policy does not meet the Claims Administrator's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness, or is determined to be experimental or investigational, and the requested benefit is denied, reduced, in whole or in part, or terminated; 2) A denial, reduction, in whole or in part, or termination based on the Student Health Plan Manager's determination that the Covered Individual was not eligible for coverage under the Plan; or, 3) Any prospective or retrospective review determination that denies, reduces, in whole or in part, or terminates a request for benefits under the Plan.

Authorized Representative means 1) a person to whom a Covered Individual has given express written consent to represent the Covered Individual; 2) a person authorized by law to provide substituted consent for a Covered Individual; 3) a Covered Individual's family member or health care provider when the

Covered Individual is unable to provide consent; or 4) in the case of an urgent care request, a health care professional with knowledge of the Covered Individual's medical condition.

Evidenced–based Standard means the conscientious, explicit and judicious use of the current best evidence based on the overall systematic review of the research in making decisions about the care of individual patients.

Final Adverse Determination means an Adverse Determination involving a Covered Medical Expense that has been upheld by the Claims Administrator, Pharmacy Benefit Manager, or Student Health Plan Manager at the completion of the internal appeal process or an Adverse Determination for which the internal appeals process has been deemed exhausted in accordance with this notice.

Prospective Review means Utilization Review performed: (1) prior to an admission or the provision of a health care service or course of treatment; and (2) in accordance with the Claims Administrator's requirement that the service be approved, in whole or in part, prior to its provision.

Retrospective Review means any review of a request for a Covered Medical Expense that is not a Prospective Review request. Retrospective review does not include the review of a claim that is limited to the veracity of documentation or accuracy of coding.

Urgent Care Request means a request for a health care service or course of treatment with respect to which the time periods for making a non-urgent care request determination:

1. Could seriously jeopardize the life or health of the Covered Individual or the ability of the Covered Individual to regain maximum function; or

2. In the opinion of a physician with knowledge of the Covered Individual's medical condition, would subject the Covered Individual to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.

Utilization Review means a set of formal techniques designed to monitor the use of or evaluate the Medical Necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers or facilities. Techniques may include ambulatory review, Prospective Review, second opinion, certification, concurrent review, case management, discharge planning, or Retrospective Review.

INTERNAL REVIEW PROCESS

Within 180 days after receipt of a notice of an Adverse Determination, a Covered Individual or an Authorized Representative may submit a written request to the Claims Administrator for an Internal Review of an Adverse Determination.

Prior to issuing or providing a notice of Final Adverse Determination, the Claims Administrator shall provide, free of charge and as soon as possible 1) any new or additional evidence considered by the Claims Administrator in connection with the grievance, and 2) any new or additional rationale upon which the decision was based.

The Covered Individual or Authorized Representative shall have 10 calendar days to respond to any new or additional evidence or rationale.

The Claims Administrator shall issue a Final Adverse Decision in writing or electronically to the Covered Individual or the Authorized Representative as follows:

1. For a Prospective Review, the notice shall be made no later than 30 days after the Claims Administrator's receipt of the grievance.

2. For a Retrospective Review, the notice shall be made no later than 30 days after the Claims Administrator's receipt of the grievance.

Time periods shall be calculated based on the date the Claims Administrator receives the request for the Internal Review, without regard to whether all of the information necessary to make the determination accompanies the request.

The written notice of Final Adverse Determination for the Internal Review shall include:

1. Information sufficient to identify the claim involved in the grievance, including the following:

   a. the date of service;

   b. the name health care provider; and

   c. the claim amount;

2. A statement that the diagnosis code and treatment code and their corresponding meanings shall be provided to the Covered Individual or the Authorized Representative, upon request;
3. For an Internal Review decision that upholds the Claims Administrator's original Adverse Determination:

   a. the specific reason(s) for the Final Adverse Determination, including the denial code and its corresponding meaning, as well as a description of the Claims Administrator's standard, if any, that was used in reaching the denial;

   b. reference to the specific Policy provisions upon which the determination is based;

c. a statement that the Covered Individual is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Covered Individual's benefit request;

d. if applicable, a statement that the Claims Administrator relied upon a specific internal rule, guideline, protocol, or similar criterion and that a copy will be provided free of charge upon request;

e. if the Final Adverse Determination is based on a Medical Necessity or experimental or investigational treatment or similar exclusion or limitation, a statement that an explanation will be provided to the Covered Individual free of charge upon request;

f. instructions for requesting:

(i) a copy of the rule, guideline, protocol or other similar criterion relied upon to make the Final Adverse Determination; and

(ii) the written statement of the scientific or clinical rationale for the determination;

4. A description of the procedures for obtaining an External Independent Review of the Final Adverse Determination pursuant to the State's External Review legislation; and
5. The Covered Individual's right to bring a civil action in a court of competent jurisdiction.
6. Notice of the Covered Individual's right to contact the commissioner's office or ombudsman's office for assistance with respect to any claim, grievance or appeal at any time.

Expedited Internal Review (EIR) of an Adverse Determination

The Covered Individual or an Authorized Representative may submit an oral or written request for an Expedited Internal Review (EIR) of an Adverse Determination:

1. Involving Urgent Care Requests; and

2. Related to a concurrent review Urgent Care Request involving an admission, availability of care, continued stay or health care service for an Covered Individual who has received emergency services, but has not been discharged from a facility.

All necessary information, including the Claims Administrator's decision, shall be transmitted to the Covered Individual or an Authorized Representative via telephone, facsimile or the most expeditious method available. The Covered Individual or the Authorized Representative shall be notified of the EIR decision

no more than seventy-two (72) hours after the Claims Administrator's receipt of the EIR request.

If the EIR request is related to a concurrent review Urgent Care Request, benefits for the service will continue until the Covered Individual has been notified of the final determination.

At the same time a Covered Individual or an Authorized Representative files an EIR request, the Covered Individual or the Authorized Representative may file:

1. An Expedited External Review (EER) request if the Covered Individual has a medical condition where the time frame for completion of an EIR would seriously jeopardize the life or health of the Covered Individual or would jeopardize the Covered Individual's ability to regain maximum function; or

2. An Expedited Experimental or Investigational Treatment External Review (EEIER) request if the Adverse Determination involves a denial of coverage based on the a determination that the recommended or requested service or treatment is experimental or investigational and the Covered Individual's treating Physician certifies in writing that the recommended or requested service or treatment would be significantly less effective if not promptly initiated.

The notice of Final Adverse Determination may be provided orally, in writing, or electronically.

EXTERNAL INDEPENDENT REVIEW

A Covered Individual or Authorized Representative may submit a request for an External Independent Review when the service in question:

1. Is a Covered Medical Expense under the Plan; and

2. Is not covered because it does not meet the Claims Administrator's requirements for Medical Necessity, appropriateness, health care setting, level of care, effectiveness, or the treatment is determined to be experimental or investigational.

A request for an External Independent Review shall not be made until the Covered Individual or Authorized Representative has exhausted the Internal Appeals process. The Internal Appeal Procedure shall be considered exhausted if:

1. The Claims Administrator has issued a Final Adverse Determination as detailed herein;

2. The Covered Individual or the Authorized Representative filed a request for an Internal Appeal and has not received a written decision from the

Claims Administrator within 30 days and the Covered Individual or Authorized Representative has not requested or agreed to a delay;

3. The Claims Administrator fails to strictly adhere to the Internal Appeal process detailed herein; or

4. The Claims Administrator agrees to waive the exhaustion requirement.

After exhausting the Internal Appeal process, and after receiving notice of an Adverse Determination or Final Adverse Determination, a Covered Individual or Authorized Representative has 4 months to request an External Independent Review. Except for a request for an Expedited External Review, the request for an External Review should be made in writing to the Claims Administrator. Upon request of an External Review, the Claims Administrator shall provide the Covered Individual or the Authorized Representative with the appropriate forms to request the review.

I. Standard External Review (SER) Process

1. Within 5 business days after receiving the SER request notice, the Claims Administrator will complete a preliminary review to determine that:

a. the individual was an Covered Individual covered under the Policy at the time the service was requested or provided;

b. the Covered Individual has exhausted the Claims Administrator's Internal Appeal Process;

c. the Covered Individual has provided all the information and forms necessary to process the request; and

d. the service in question: (i) is a Covered Medical Expense under the Policy; and (ii) is not covered because it does not meet the Claims Administrator's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness.

2. Within 1 business day after completion of the preliminary review, the Claims Administrator shall notify the Commissioner, the Covered Individual and, if applicable, the Authorized Representative in writing whether the request is complete and eligible for a SER.

a. If the request is not complete, the Claims Administrator's response shall include what information or materials are needed to make the request complete;

b. If the request is not eligible, the Claims Administrator's response shall include the reasons for ineligibility. The Covered Individual and, if applicable, the Authorized Representative shall also be advised of the right to appeal the decision to the Commissioner.

3. After receiving notice that a request is eligible for SER, the Commissioner shall, within 1 business day:

a. Assign an Independent Review Organization (IRO) from the Commissioner's approved list;

b. Notify the Claims Administrator of the name of the assigned IRO; and

c. Notify the Covered Individual and, if applicable, the Authorized Representative, that the request has been accepted.

This notice shall include: (i) the name of the IRO; and (ii) a statement that the Covered Individual or the Authorized Representative may, within 5 business days following receipt of the notice, submit additional information to the IRO for consideration when conducting the review.

4. a. The Claims Administrator shall, within 5 business days, provide the IRO with any documents and information the Claims Administrator considered in making the Adverse Determination or Final Adverse Determination. The Claims Administrator's failure to provide the documents and information will not delay the SER.

b. If the Claims Administrator fails to provide the documents and information within the required time frame, the IRO may terminate the review and may reverse the Adverse Determination or Final Adverse Determination. Upon making this decision, the IRO shall, within 1 business day, advise the Commissioner, the Claims Administrator, the Covered Individual, and the Authorized Representative, if any, of its decision.

5. The IRO shall review all written information and documents submitted by the Claims Administrator and the Covered Individual or the Authorized Representative.

6. If the IRO receives any additional information from the Covered Individual or the Authorized Representative, the IRO must forward the information to the Claims Administrator within 1 business day.

a. The Claims Administrator may then reconsider its Adverse Determination or Final Adverse Determination. Reconsideration by the Claims Administrator shall not delay or terminate the SER.

b. The SER may only be terminated if the Claims Administrator decides to reverse its Adverse Determination or Final Adverse Determination and provide coverage for the service that is the subject of the SER.

c. If the Claims Administrator reverses it decision, the Claims Administrator shall provide written notification within 1 business day to the Commissioner, the Covered Individual, the Authorized Representative, if applicable, and the IRO.

Upon written notice from the Claims Administrator, the IRO will terminate the SER.

7. Within 45days after receipt of the SER request, the IRO shall provide written notice of its decision to uphold or reverse the Adverse Determination or Final Adverse Determination. The notice shall be sent to the Commissioner, the Claims Administrator, the Covered Individual and, if applicable, the Authorized Representative. Upon receipt of a notice of decision reversing the Adverse Determination or Final Adverse Determination, the Claims Administrator shall immediately approve the coverage that was the subject of the Adverse Determination or Final Adverse Determination.

II. Expedited External Review (EER) Process

1. The Covered Individual or an Authorized Representative may make a written or oral request for an Expedited External Review (EER) with the Claims Administrator at the time the Covered Individual receives:

a. An Adverse Determination if:

(i) the Covered Individual or the Authorized Representative has filed a request for an Expedited Internal Review (EIR); and

(ii) the Adverse Determination involves a medical condition for which the timeframe for completing an EIR would seriously jeopardize the life or health of the Covered Individual or jeopardize the Covered Individual's ability to regain maximum function; or

b. A Final Adverse Determination, if:

(i) the Covered Individual has a medical condition for which the timeframe for completing a Standard External Review (SER) would seriously jeopardize the life or health of the Covered Individual or jeopardize the Covered Individual's ability to regain maximum function; or

(ii) the Final Adverse determination involves an admission, availability of care, continued stay or health care service for which the Covered Individual received emergency services, but has not been discharged from a facility.

An EER may not be provided for retrospective Adverse Determinations or Final Adverse Determinations.

2. Upon receipt of a request for an EER, the Claims Administrator shall immediately review the request to determine that:

a. the individual was an Covered Individual covered under the Policy at the time the service was requested or provided;

b. the Covered Individual has exhausted the Claims Administrator's Internal Appeal Process, unless the Covered Individual is not required to do so as specified in sections II. 1. a. and b. shown above;

c. the Covered Individual has provided all the information and forms necessary to process the request; and

d. the service in question: (i) is a Covered Medical Expense under the Policy; and (ii) is not covered because it does not meet the Claims Administrator's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness.

3. Immediately after completion of the review, the Claims Administrator shall notify the Commissioner, the Covered Individual and the Authorized Representative, if applicable, whether the request is eligible for an EER.

a. If the request is not complete, the Claims Administrator's response shall include what information or materials are needed to make the request complete;

b. If the request is not eligible, the Claims Administrator's response shall include the reasons for ineligibility. The Covered Individual and, if applicable, the Authorized Representative shall also be advised of the right to appeal the decision to the Commissioner

4. When a request is complete and eligible for an EER, the Commissioner shall immediately assign an IRO from the Commissioner's approved list and notify the Claims Administrator of the name of the assigned IRO.

a. The Claims Administrator shall provide or transmit all necessary documents and information considered in making the Adverse Determination or Final Adverse Determination.

b. All documents shall be submitted to the IRO electronically, by telephone, via facsimile, or by any other expeditious method.

5. a. If the EER is related to an Adverse Determination for which the Covered Individual or the Authorized Representative filed the EER concurrently with an Expedited Internal Review (EIR) request, then the IRO will determine whether the Covered Individual shall be required to complete the EIR prior to conducting the EER.

b. The IRO shall immediately notify the Covered Individual and the Authorized Representative, if applicable, that the IRO will not proceed with EER until the Claims Administrator completes the EIR and the Covered Individual's grievance remains unresolved at the end of the EIR process.

6. In no more than 72 hours after receipt of the qualifying EER request, the IRO shall:

a. Make a decision to uphold or reverse the Adverse Determination or Final Adverse Determination; and

b. Notify the Commissioner, the Claims Administrator, the Covered Individual, and, if applicable, the Authorized Representative.

7. Upon receipt of a notice of decision reversing the Adverse Determination or Final Adverse Determination, the Claims Administrator shall immediately approve the coverage that was the subject of the Adverse Determination or Final Adverse Determination.

8. Kentucky Insurance Department contact information is provided below:

Kentucky Public Protection Cabinet

Department of Insurance

P.O. Box 517, Frankfort, KY 40602-0517

800-595-6053 (in KY); 502-564-3630 (out of state); TDD: 800-648-6056

http://insurance.ky.gov/

BINDING EXTERNAL REVIEW

An External Review decision is binding on the Claims Administrator except to the extent the Claims Administrator has other remedies available under state law. An External Review decision is binding on the Covered Individual except to the extent the Covered Individual has other remedies available under applicable federal or state law. A Covered Individual or an Authorized Representative may not file a subsequent request for External Review involving the same Adverse Determination or Final Adverse Determination for which the Covered Individual has already received an External Review decision.