



UK Albert B. Chandler Hospital, open May 2011

UK-HMO

2011-12

LEXINGTON SERVICE AREA

Certificate of Coverage

Description of Benefits and Services

With Autism Addendum to COC - Page 73

With Appeal Language Change - Page 11

For the most up-to-date provider listings,
please visit our Web site at www.mc.uky.edu/ukhmo.

UK-HMO LEXINGTON SERVICE AREA
KENTUCKY REQUIRED COVER SHEET

July 1, 2011-June 30, 2012

READ YOUR CERTIFICATE CAREFULLY. This Cover Sheet provides only a brief outline of some of the important features of your policy.

IT IS, THEREFORE, IMPORTANT THAT YOU READ YOUR CERTIFICATE CAREFULLY.

This is a Certificate of Coverage but is not a legal document. The coverage of a Member can be terminated for non-payment of Premium, fraud or misrepresentation, intentional and abusive non-compliance with Plan provisions, Service Area limitations, uniform discontinuance of a type of coverage, or if the UK-HMO ceases to do business. Review your Certificate carefully for further information on these provisions. Modifications to the Plan may be made at the time of renewal or as required by law.

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

By enrolling and accepting benefits under this Certificate, the Member agrees to abide by the rules outlined in this Certificate. Except for Emergency Health Services, only those health care services provided by or arranged by a UK Participating Provider and authorized by the Plan or its Medical Director (when applicable) are a benefit under this certificate. Members are entitled to the health maintenance organization services and benefits described in this Certificate in exchange for the Premium paid to the University of Kentucky Medical Benefits Plan and a fee paid to us by the University of Kentucky.

If you have questions regarding this Certificate or any of the benefits provided herein, you may contact us at
1-800-955-8547

A TABLE OF CONTENTS FOLLOWS, SHOWING YOU WHERE TO LOOK
FOR INFORMATION CONCERNING SPECIFIC AREAS.

Once again, we urge you to READ YOUR CERTIFICATE CAREFULLY.

HOW TO USE THIS CERTIFICATE

The Certificate gives the details to help you understand what health care services are covered. This Certificate of Coverage is not a legal document. The Group Contract maintained by the group is the legal contract and this Certificate is subject to its terms and conditions. In the event of conflict, the provisions of the Group Contract will prevail over this Certificate.

1. Schedule of Benefits

The Schedule of Benefits gives the amount of benefits payable, as well as Co-payments, Coinsurance, and maximums under your Certificate.

2. Plan Delivery System Rules

The Plan Delivery System Rules section explains the guidelines for the health care delivery system used by the Plan and the cost containment measures that are designed to help manage escalating health care costs. Benefits will be denied for failure to follow these provisions.

3. Definitions

This section defines words and phrases having special meanings. If a word or phrase starts with a capital letter, it has a special meaning. It is defined in the Definitions section or where used in the text, or it is a title.

4. Covered Services

This section explains health care services covered under this Plan. Each section shows what services are covered. The Schedule of Benefits gives the amount of benefits payable, as well as any Deductibles, Co-payments, Coinsurance, and maximums under your Certificate.

5. Exclusions

This section describes the types of services and supplies that are not covered, but it is not an exclusive list. Members should read this section carefully.

6. General Provisions

This section provides additional information about how coverage works. It describes such things as: who is eligible for coverage and when changes in enrollment may be made; how benefits are paid; how and when coverage terminates; and what privileges exist when coverage terminates.

7. Prescription Drugs

This section provides additional information about your pharmacy benefit. Express Scripts administers this benefit with assistance from the UK Employee Benefits Office and the UK Reach Program.

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UK-HMO SCHEDULE OF BENEFITS

All Covered Services must be provided or arranged by a UK Participating Physician. This is not a contract. It is a summary and partial listing of benefits and services. For complete details, including applicable exclusions and limitations, please refer to the appropriate section within this Certificate of Coverage.

Schedule of Benefits		
Lifetime Maximum Benefit		
Unlimited		
Preventive Care	Routine PAP smears, mammograms, PSA tests, screening colonoscopy and sigmoidoscopy. Routine child care and immunizations (through age 18) Routine adult physical exam (19 yrs and above)	\$0 Co-payment
Physician Services	Outpatient Visits (excludes certain diagnostic lab and x-ray). All services performed on the same day in the same clinic (excluding allergy injections) are subject to one Co-payment.	\$10 Co-payment for primary care providers \$20 Co-payment for specialists
	Lab tests, x-rays and diagnostic tests in provider office Inpatient services Physician visits to emergency room Outpatient surgery	\$0 Co-payment
	Allergy injection(s) (in Physicians office)	\$5 Co-payment
Hospital Services	Inpatient care (semi-private room and board, nursing care, ICU) Hospital Observation Stay	\$150 Co-payment per admission \$75 Co-payment per observation stay
	Organ transplants Outpatient non-surgical care Outpatient tests, lab and x-ray, and other diagnostic tests Ancillary services Outpatient surgery Outpatient diagnostic testing (High Cost - MRI, MRA, CT, PET, and SPECT scans)	100% covered \$50 Co-payment
Emergency Services	Hospital Emergency Room (ER Co-payment waived if admitted as an Inpatient or Observation stay. Inpatient or Observation Co-payments would then apply.)	\$75 Co-payment
	UK-HMO participating Urgent Care Centers (Lexington UTC: Boardwalk, Custer, Dove Run or Nicholasville UTC: Bellaire Drive)	\$25 Co-payment per visit
	UK Children's Twilight Clinic (not Hospital emergency room)	\$15 Co-payment per visit
	Ambulance (including Air Ambulance). <i>Non-emergent ambulance is only covered when transported to UK or Samaritan Hospitals.</i>	\$75 Co-payment
Maternity Care	Prenatal, labor, delivery, postpartum care. No office visit co-pay is required.	\$0 Co-payment; Hospital Inpatient Co-payment applies upon admission.
Mental Health & Substance Abuse	Inpatient (per admission)	\$150 Co-payment;
	Outpatient (per visit)	\$20 Co-payment

<p>Outpatient Therapies</p> <ul style="list-style-type: none"> • Physical Therapy • Occupational Therapy • Manipulative Therapy (Chiropractic and Osteopathic) • Pool Therapy/Exercise Hydrotherapy • Acupuncture • Speech Therapy • Cardiac Rehabilitation • Pulmonary Rehabilitation 	<p>(The co-pay is per visit - All services performed on the same day for the same type of therapy are subject to one co-payment)</p>	<p>\$15 Co-payment per visit</p> <p>Limit 45 visits per plan year combined (July-June)</p> <p><i>(If a UK-HMO member completes at least 24 Cardiac or Pulmonary Rehab visits, UK-HMO will refund 50% of their co-pays for these specific services)</i></p>
<p>Home Health Services</p>	<p>Intermittent skilled nursing and health related services to Members in their home under a plan prescribed by a Physician.</p>	<p>20% Coinsurance; Limit 60 visits per plan year (July-June)</p>
<p>Other Services</p>	<p>Autism - \$500 maximum monthly benefit for children 2-21 years of age for therapeutic, Respite, and rehabilitative care</p> <p>Skilled Nursing/Inpatient Rehabilitation</p> <p>Hearing Aids</p> <p>Hospice</p>	<p>50% Coinsurance</p> <p>\$0 Co-payment; Limit 30 days per plan year combined benefit (July-June)</p> <p>\$0 Co-payment (\$1,400 benefit per ear every 36 months for children under age 18)</p> <p>100% covered</p>
<p>Tobacco Cessation Counseling</p>	<p>Tobacco Cessation Counseling</p>	<p>\$5 co-payment</p>
<p>Durable medical equipment (DME), prosthetics, and orthotics (Items over \$750 and rentals Requires Prior Plan Approval)</p>	<p>DME, Prosthetics and Orthotics (\$400 maximum out-of-pocket per plan year for these services, then covered in full).</p>	<p>20% Coinsurance</p>
<p>Prescription Drugs</p>	<p>Effective 7/1/03 prescription drugs are covered under a separate plan through Express Scripts and UK Employee Benefits</p>	<p>See Page 56</p>

Plan Year - Each successive twelve-month period starting on July 1 and ending on the next June 30th.

Lifetime Maximum Benefit - There is no Lifetime Maximum Benefit limit.

Annual Deductible - None

Co-payments - The amount you pay to the Provider at the time of service for those services to which a Co-payment applies, as specified in the Schedule of Benefits.

Coinsurance - The percentage of the Eligible Expense you pay for those services to which a Coinsurance applies, as specified in the Schedule of Benefits. Coinsurance is calculated based on the Eligible Expense. You are not responsible for the amount above the Eligible Expense.

DELIVERY SYSTEM RULES HOW TO USE YOUR HMO PLAN

If you do not follow the Plan's Delivery System Rules your claims will be denied.

INTRODUCTION

Thank you for joining UK-HMO Lexington Service Area (LSA). Your HMO benefit plan offers you access to Covered Services through the University of Kentucky (UK) Chandler Medical Center, the UK Samaritan Hospital, the Kentucky Clinics, and any other UK-HMO participating providers. Follow the rules in this section when seeking services covered by this benefit plan. When you follow the rules, you will find your health benefits are easy to use. Member Services can help you when you have questions or concerns. Call Member Services at the phone number listed on your Identification Card.

UK-HMO BENEFITS

This benefit plan provides benefits for Covered Services when you use UK-HMO Participating Providers. For those services that require Prior Plan Approval, the Plan administrator must approve the service in advance. See the Prior Plan Approval list beginning on page 9. If approval is not issued prior to the service, benefits are denied. It is your responsibility to make sure that the Providers you see are Participating Providers in the UK-HMO LSA Network. Coverage is provided for emergency care at a non-participating facility only if your condition is an emergency condition as determined by the Plan. To find out if a Provider is a UK-HMO LSA Participating Provider, visit our Web site at www.mc.uky.edu/ukhmo or call Member Services.

UK-HMO LEXINGTON SERVICE AREA

The geographic area approved by state regulatory authorities, which is served specific to this UK-HMO benefit structure, consists of the following Kentucky counties: Anderson, Bourbon, Clark, Fayette, Franklin, Jessamine, Madison, Mercer, Scott, and Woodford.

UK-HMO LSA PROVIDER NETWORK

The UK-HMO Network includes the (UK) Chandler Medical Center, the UK Samaritan Hospital, the Kentucky Clinics, and any other UK-HMO participating provider. The University of Kentucky provides you with access to Providers in nearly every field of medicine and health care. The list of Physicians and their ability to accept new patients is subject to change. Please refer to the on-line search at www.humana.com/members/tools for the most up to date participating providers. You can find the type of provider you are looking for at the bottom right corner of this page by searching the UK-HMO LSA Network. Please call Member Services at 1-800-955-8547 if you have a question or concern about a Participating Provider.

Requests for In-Network Coverage of Services from Non-Participating Providers - You may ask UK-HMO to cover services from Non-Participating Providers at the In-Network benefit. The Plan approves such requests only when the Plan determines in advance that treatment for your condition is not available from UK-HMO Participating Providers. All requests must be made in writing and sent to Medical Management. Your treating physician must submit the following:

1. The reasons why the treatment for your condition cannot be performed by UK Providers, and
2. Sufficient clinical information about your condition to allow Medical Management to determine:
 - a) the medical necessity for your request,
 - b) the requested service is a covered UK-HMO benefit.
 - c) services are not available by a UK Provider

Your request will be considered through the Prior Plan Approval process and a decision rendered according to the timeframes for Prior Plan Approval (page 12). **Unless authorized by the plan, services are not covered for out of network providers.**

IDENTIFICATION CARD

Carry your Identification (ID) Card at all times. Present it each time you receive medical services. Failure to do so could result in member financial responsibility. Your ID card contains the following:

- Identification Number
- Group Number
- Co-payment information
- Telephone numbers for contacting the Plan.

IDENTIFICATION CARD (cont.)

Only you and your enrolled Dependents may use your ID Card or file for benefits. Contact Member Services if you need a new ID card or you may order replacement ID cards through MyHumana by accessing the UK-HMO Web site at www.mc.uky.edu/ukhmo. Choose MyHumana and either register to create an account or choose the log in link at the bottom of the page.

MyHumana

As your trusted partner in health care, we believe that making health information easy to access is important. That's why we've created a secure member Web site, MyHumana, which you can access through the UK-HMO Web site (www.mc.uky.edu/ukhmo). From MyHumana you can view claims, authorizations, and benefit such as Co-payments and your Certificate of Coverage. By using your unique username and password to log on, security and confidentiality are assured. MyHumana is available when you need it, 24 hours a day, 7 days a week. To use MyHumana, just set up your MyHumana account through the UK-HMO Web site at www.mc.uky.edu/ukmo and choose the MyHumana button. At the bottom of the page choose "Join myHumana for a MyHumana Account" or "Log Into MyHumana". When signed onto this site, you may also access medical information to help you make informed health care decisions. Members and Providers can find a variety of topics, including the newest diagnostic procedures, surgeries, and much more.

CO-PAYMENTS/COINSURANCE

Co-payments: Pay your Co-payment at the time of service.

Coinsurance: Providers usually bill you for the Coinsurance after the Plan pays the claim. The Coinsurance amount is based on the Plan's Eligible Expense. For services from Participating Providers, you are not responsible for the amount above the Eligible Expense.

UK PRIMARY CARE PHYSICIAN (PCP)

Although you are not required to select a Primary Care Physician, a UK PCP is the appropriate person to provide your medical care and coordinate your care with other UK Participating Providers. A UK PCP should be your first contact for all of your non-emergency medical needs. You can choose a Family Practice, General Practice, Internal Medicine or Pediatric Physician as a PCP. To verify the list of PCP's, visit www.humana.com/members/tools web site or contact Customer Services. It's a good idea to make an appointment with your new PCP for a routine exam. Your PCP will need your medical history to care for you if you become ill. We also recommend that you have your medical records transferred to your new PCP. The Primary Care Physicians are listed in the UK-HMO LSA on-line Provider Network.

REFERRALS FOR SPECIALTY CARE

Your Plan does not require you to obtain a referral for specialty care provided by UK specialists. However, some UK specialists may require a referral from your PCP. Keep in mind that Prior Plan Approval (PPA) is required for certain services listed on page 9. These services are not covered unless you receive Prior Plan Approval no matter who performs the service.

SECOND OPINIONS

If you choose to obtain a second opinion from a UK Provider regarding surgery or treatment, it is covered just as any other specialty office visit. All Plan Delivery System Rules apply to second opinions.

MENTAL HEALTH AND CHEMICAL DEPENDENCE

If you need Mental Health or Chemical Dependence services, you or your Physician may arrange for Outpatient services by a UK Participating Provider without notifying the Plan or obtaining authorization from the Plan. Inpatient, partial hospital and intensive outpatient services require Prior Plan Approval. See page 9 for a list of services that require Prior Plan Approval.

EMERGENCY AND URGENT CARE

Benefits are provided for treatment of Emergency Medical Conditions and emergency screening and stabilization services without Prior Plan Approval. Services are covered for conditions that reasonably appear to a prudent layperson to constitute an Emergency Medical Condition based on the presenting symptoms and conditions. See the definition of an Emergency Medical Condition in the Definitions section of the COC. If you feel you have an Emergency Medical Condition, you should go to the UK Chandler or UK Samaritan Emergency Room. If your

EMERGENCY AND URGENT CARE (cont.)

condition makes travel to the UK Emergency Room unsafe or if you are out of the Service Area, go to the nearest emergency medical facility. If necessary, call 911. It is recommended that you notify your personal physician within 24 hours or as soon as reasonably possible. Follow-up care is not considered emergency care

Medically Necessary services which the Plan determines meet the definition of an Emergency Medical Condition will be covered whether the care is rendered by a Participating or a Non-Participating Provider. Treatment for an Emergency Medical Condition rendered by a Non-Participating Provider will be covered and reimbursed by the Plan at the In-Network benefit level. If your hospital care is provided by a Non-Participating Provider, we may arrange your transfer to a Participating Hospital when you are medically stabilized. Care and treatment provided after you are stabilized is not emergency care.

Whenever you need Urgent Care:

Urgent Care benefits are limited to services for a condition that requires prompt medical attention. If you are outside the Service Area, benefits are limited to services that you did not expect to require before leaving the Service Area.

In-Area Urgent Care

- 1) Call your PCP for assistance.
- 2) Go to the nearest Participating facility providing Urgent Care (Urgent Treatment Centers: Lexington: Boardwalk, Dove Run, Custer Drive, or Sir Barton Way; Nicholasville: Bellaire Drive; or Georgetown: Eastside Drive; UK Children's Twilight Clinic; UK Medical Center Emergency Room or Good Samaritan Emergency Room). You will be responsible for your Co-payment amount as specified in the Schedule of Benefits.

For follow-up care, contact your UK participating physician.

STUDENTS AWAY FROM HOME

If your Dependent attends school outside the Service Area, all Plan Delivery System Rules apply. Routine services must be received from a UK-HMO LSA Participating Provider. See above for Emergency and Urgent Care coverage.

UTILIZATION MANAGEMENT

Your Plan requires that certain services be approved before the service is rendered. Prior Plan Approval is the formal assessment of the Medical Necessity, efficacy, and/or appropriateness of health care services and place of service. In addition, some services require only that your Provider notify us before you receive the service.

If a service requires Prior Plan Approval or notification and the service is provided without approval, the claim will be denied.

LEXINGTON SERVICE AREA (LSA)
 SERVICES THAT REQUIRE PRIOR PLAN APPROVAL

Phone: (800) 491-4421 ext 4584 or (800) 955-8547

A Prior Plan Approval List is included below. The list of services requiring Prior Plan Approval or notification is subject to change. You may call Member Services during business hours for information regarding the PPA List. The following list represents services that require approval before the service is rendered. In addition, certain new medical technologies for diagnosis and treatment require Prior Plan Approval.

Services	
• Hospital inpatient admissions	• Organ transplants/blood and marrow transplants
• Skilled Nursing Facility (SNF) admissions	• Rehabilitation facility admissions
• Mental health and substance abuse facility inpatient, partial hospital and intensive outpatient services	• Nonemergent medical transportation
• Long-term Acute Care	• Durable Medical Equipment (DME) purchases costing more than \$750 and all DME rentals
• Orthotics — professionally fitted braces and splints costing more than \$750	• Prosthetics — artificial limbs
Procedures, tests and services	
• Abdominoplasty	• Accidental dental and general anesthesia benefit
• Benign skin lesion removal	• Blepharoplasty
• Breast reduction/augmentation	• Cochlear implant
• Coronary CT angiography (Reviewed by Humana)	• Home health services
• Hospice	• *Hyperbaric Therapy
• Immunization – some nonroutine immunizations including, but not limited to, Lyme Disease, RSA, Synagis, meningococcus	• Medication Preauth List (see page 2 & 3)
• Molecular Diagnostic/Genetic Testing*	• Neuropsychological testing
• Non-participating Physician/Facility Requests	• Nutritional counseling (other than diabetes)
• Oral surgery	• Plastic or cosmetic surgery
• Pulmonary rehab	• Rhinoplasty
• Sclerotherapy	• Septoplasty
• Speech Therapy	• Surgery for snoring or sleep apnea (e.g. UPPP)
• Temporomandibular joint (TMJ) procedures	
Radiology Services (authorized by HealthHelp at 1-866-825-1550)	
(MRIs; CAT scans; or PET scans (except Coronary CT Angiography - which are reviewed by Humana), do not require authorization when done at UK Chandler or UK Good Samaritan Hospitals)	

* **Molecular diagnostic/genetic testing (MD/GT)** These services are administered by DNA Direct, a provider of MD/GT management services. UK-HMO requires that all requests for authorization of MD/GT be submitted to the Genetic Guidance Center at DNA Direct. Preauthorization requests may be submitted via the following options:

- Accessing DNA Direct’s Web site at <http://humana.dnadirect.com>
- Calling Humana’s Genetic Guidance Center at DNA Direct at 1-877-506-5193, 8 a.m. to 8 p.m. Eastern time, Monday through Friday

Please note: The following categories are excluded from this requirement: routine prenatal screening, routine inpatient newborn screenings, human leukocyte antigen (HLA) testing for transplant, chromosomal analysis for leukemia and lymphoma, and infectious disease testing considered to be standard of care.

UK-HMO Medication Preauthorization List

For authorizations, contact the Medication Intake Team (MIT) at (866) 461-7273 or fax to 1-888-447-3430 – Refer to the following website for customized fax forms

http://www.humana.com/providers/tools/prescription_tools/pre_certification.asp

<i>Preauthorization is required for the following drugs when delivered in the physician's office, clinic, outpatient or home setting.</i>			
Brand	Generic	Brand	Generic
Actemra	Toclizumab	*Lumizyme	*aiglucosidase alfa
*Alimta	*pemetrexed	Mozobil	perixafor
Aloxi	palonosetron HCl	Myobloc	botulinum toxin type B
Aranesp	darbepoetin alfa	*Myozyme	*aiglucosidase alfa
Arcalyst	rilonacept	Neulasta	pegfilgrastim
Arzerra	Ofatumumab	Nplate	romiplostim
Avastin	bevacizumab	Orencia	abatacept
Avonex	interferon beta-1a	Ozurdex	Dexamethasone intravitreal implant
Berinert	C1 esterase inhibitor	Pegasys	peginterferon alfa-2a
Betaseron	interferon beta-1b	Pegintron	peginterferon alfa-2b
Boniva	ibandronate sodium	Procrit	epoetin alfa
Botox	botulinum toxin type A	Prolia	Denosumab
Cerezyme	imiglucerase	Provence	Sipuleucel-T
Cimzia	certolizumab pegol	Qutenza	Capsaicin/skin cleanser
Cinryze	c1 esterase inhibitor	Rebif	interferon beta-1a
Copaxone	glatiramer acetate	Reclast	zoledronic acid
Dacogen	decitabine	Relistor	methylnaltrexone bromide
Dysport	abobotulinumtoxin A	Remicade	infliximab
Emend IV	aprepitant	Remodulin	treprostinil (injection)
Enbrel	Etanercept	Revatio	sildenafil citrate (injection)
Epogen	Epoetin alfa	Rituxan	rituximab
Erbix	Cetuximab	Sandostatin LAR	octreotide
Extavia	interferon beta-1b	Simponi	golimumab
Flolan	epoprostenol (injection)	Soliris	eculizumab
Forteo	teriparatide	Somavert	pegvisomant
Folotylin	pralatrexate	Stelara	ustekinumab
Fusilev	levoleucovorin	Synagis	palivizumab
Growth Hormones: Genotropin, Humatrope, Increlex, Norditropin, Nutropin, Nutropin AQ, Omnitrope, Saizen, Serostim, Tev-Tropin, Zorbtive	somatropin	Torisel	temsirolimus
Halaven	*eribulin mesylate	Treanda	bendamustine HCL
Herceptin	trastuzumab	Tyvaso	treprostinil (inhaled)
Humira	adalimumab	Vectibix	panitumumab
Ilaris	canakinumab	Velcade	bortezomib
Immune Globulin: Baygam, Carimune NF, Flebogamma 5%, Gamastan, Gammagard S/D, Gammagard Liquid, Gamunex, Hizentra, Iveegam, Octagam, Polygam S/D, Privigen, Vivaglobulin	immune globulin	Ventavis	iloprost (inhaled)
Increlex	mecasermin	Vidaza	azacitidine
Istodax	Romidepsin	Vpriv	velaglucerase alfa
Ixempra	ixabepilone	*Xeomin	*incobotulinumtoxin A
Jevtana	cabazitaxel	*Xgeva	*denosumab
Kineret	anakinra	Xolair	omalizumab
*Krystexxa	*pegloticase	Zometa	zoledronic acid
Lucentis	ranibizumab		

* New preauthorization requirement

Timeframes for Prior Plan Approval: Upon receipt of the complete information needed to make the decision, a decision is rendered:

- For Urgent Care - within 72 hours
- For Non-Urgent Care - within 15 days
- For Concurrent Review - within 24 hours
- For Retrospective Review - within 30 days

The Plan utilizes objective clinical criteria in determining the Medical Necessity and appropriateness of procedures and services.

The Plan reviews the medical information provided by your Physician or facility to determine if the criteria are met. If the request is appropriate with respect to the clinical criteria, approval is granted. All requests for Prior Plan Approval that do not meet the Plan's criteria are reviewed by a Plan Medical Director or a Physician Advisor. Denials based on Medical Necessity and appropriateness is made only by a licensed Physician. Denials are communicated to the Provider by telephone or fax and to you and the Provider by mail.

In general, you are not responsible for payment of Covered Services if a Participating Physician or facility fails to obtain the necessary approval or provides services for which coverage has been denied through the Prior Plan Approval process. However, to avoid unnecessary delays and confusion, you should confirm that the necessary approval has been obtained. You may check if a service is approved through UK-HMO's Web site link to MyHumana using your security password. You can also call Customer Services to check on an approval.

The list of services requiring approval for coverage is subject to change. Your Physician may call the Medical Management Department to verify if approval is required for a specific procedure. If you are not sure what services require approval, call Member Services.

If you disagree with a Plan's Prior Plan Approval decision, you may appeal the decision. Instructions for appeals are on page 13 - 14. Please remember that Prior Plan Approval decisions are made on the basis of objective medical appropriateness criteria. Appeals should include additional medical information establishing that the criteria have been met or that the criteria have been misapplied. The Plan may determine that a service ordered, prescribed, or recommended by a Provider does not meet the criteria set forth in the definition of Medically Necessary and therefore that service is not covered. The Plan has contractual agreements with its Participating Providers that prohibit them from billing Members for services that the Plan determines are not Medically Necessary. If you have questions regarding the appeal process, contact Member Services.

Medical Technology Assessment

The Plan periodically reviews and evaluates new medical technology for benefit inclusion. You may request this review directly or through your PCP or specialist. The Plan may cover new technology based on a review of published peer reviewed evidence of safety, long term positive health outcomes and cost effectiveness comparable to existing therapies. The Plan also uses reports of an independent review organization and communication with medical experts, as appropriate.

Hospital Care Management

Medical Management nurses will work with your Physician to help arrange the necessary medical care in the most appropriate setting. If Inpatient admission is appropriate, a Medical Management nurse will monitor your case throughout the admission. The Plan's nurse may also assist your Physician to arrange any services you may need after discharge.

Organ Transplant Case Management

The Plan's transplant case manager provides help to Members who may need an organ transplant. Your benefits cover transplants only when approved in advance by the Plan and provided by UK-HMO designated transplant facilities. To contact the transplant case manager, call Member Services. The case manager will review your specific needs with you and your doctor, and, if you wish, help arrange care.

PROTECTING YOUR HEALTH INFORMATION

UK-HMO and their Third Party Administrator (TPA) protect the privacy of health information. Information about your health, including medical records, information about services requested and received, and claims information remains confidential to the extent necessary or as otherwise provided by law. In order to protect

PROTECTING YOUR HEALTH INFORMATION (Continued)

your health information, UK-HMO and the TPA may refuse to release information without your authorization. You may authorize release by completing an Consent for Release of Protected Health Information form. This form can be obtained in the Member Form section of Humana's Web site, which can be accessed at the bottom of the page at <http://www.humana.com/members/tools/forms.asp> or by calling Member Services at (800) 955-8547.

COMPLAINT AND GRIEVANCE PROCESS

If a Covered Person has a problem or complaint regarding any aspect of the administration of benefits by UK-HMO, the Member may contact the UKHMO Customer Services Department to discuss the matter. If the matter cannot be resolved within a reasonable time to the Member's satisfaction, the Member may submit a written appeal. The UK-HMO plan provides a five-step appeal process to resolve Member concerns. The administrative remedies established by this appeal process must be satisfied before legal remedies are sought.

Step 1 - Informal Inquiry

If you have an inquiry or complaint regarding UK-HMO's benefits, write UKHMO, Appeals Coordinator, P.O. Box 14546, Lexington, KY 40512-4546, or call Customer Services at 1-800-955-8547. Inquiries should include a summary of the issue, provide a description of any previous contact(s) with the Plan regarding the matter in question, and describe the relief sought. Most inquiries are handled immediately. If further research is required, a representative will respond to you within 7 working days. If additional information from a Non-Participating Provider is required, the Plan may need additional time to respond to your concern through all phases of the appeal process. In such cases, the Plan will notify you of any delays.

Step 2 - Written Appeal

If your concern is not settled to your satisfaction at Step 1, you may appeal the decision by submitting a written statement of concern to the Plan at UKHMO, Appeals Coordinator, P.O. Box 14546, Lexington, KY 40512-4546 within 180 days of the receipt of a denial or other action by the Plan. The statement should include a summary of the complaint or issue, information regarding previous contact(s) with the plan regarding the matter in question and a description of the relief sought. The Appeals Coordinator will acknowledge receipt of the appeal within 7 working days, investigate the matter and notify you of the Plan's decision within 30 days after receipt of the appeal.

Step 3 - Formal Grievance Hearing

If you are not satisfied with the outcome of your appeal, you may submit a written request for a hearing to the Plan Grievance Committee within 30 days after receipt of the appeal decision. The request should be directed to UKHMO, Appeals Coordinator, P.O. Box 14546, Lexington, KY 40512-4546, 'Appeals Coordinator.' The Grievance Committee will acknowledge your request within 7 working days and hear your case within 30 days. The Grievance Committee will review the appeal decision, and any additional evidence you submit, and make a recommendation. If the Grievance Committee recommends that the relief you sought be granted, you will be promptly informed. If the Grievance Committee recommends that the denial be upheld, you will be notified within 60 days.

Step 4 - Final Internal Appeal

If you are not satisfied with the outcome of the Grievance Hearing, you may submit a written request within 30 days to the Associate Vice President, Human Resource Services, at the University of Kentucky, 101 Scovell Hall, Lexington, KY 40506-0064. The statement should include a summary of the complaint or issue, information regarding previous contact(s) with the plan regarding the matter in question and a description of the relief sought. The UK Director of Employee Benefits has the discretion to establish a committee to perform the Final Appeal process. The Director and/or the committee so established, as applicable, shall review the entire grievance file, including prior decisions rendered on the matter under review, and may request additional information from the participants, prior to rendering the final appeal decision. The final appeal decision will be rendered within 30 days of request.

External Grievance Process

- (A) If a Participant has exhausted the Plan's internal appeals process and the Participant is not satisfied or the Plan failed to render a decision within the specific timeframe, a Participant may be eligible for an External Review by an Independent Review Entity under the following conditions:
- (1) The Plan made an adverse determination, as defined in KRS 304.17A-600 (1) (a); Definitions for KRS 304.17A-600 to 304.17A-633:
 - (a) "Adverse determination" means a determination by an insurer or its designee that the health care services furnished or proposed to be furnished to a covered person are:
 - i. Not medically necessary, as determined by the insurer, or its designee or experimental or investigational, as determined by the insurer, or its designee; and
 - ii. Benefit coverage is therefore denied, reduced, or terminated.
 - (b) "Adverse determination" does not mean a determination by an insurer or its designee that the health care services furnished or proposed to be furnished to a covered person are specifically limited or excluded in the covered person's health benefit plan;
 - (2) The Participant was enrolled on the date of the service, or, if prospective denial, was enrolled and eligible to receive covered benefits on the date the service was requested; and
 - (3) The entire cost of treatment or service will cost the Participant at least \$100 if not covered by the Plan.
- (B) A Participant, an authorized person or a Provider with the Participant's consent may request an External Review. The request for review must be received within 60 days after the Plan's internal appeal decision letter. The confidentiality of all records used in the review shall be maintained throughout the process. A Participant shall make a request for External Review in writing to the Plan. The written consent authorizing the Independent Review Entity to obtain all necessary medical records from both the Plan and the Provider with information related to the denied coverage shall accompany the request. The Plan shall have consent forms available to Participants upon request to a toll-free telephone number or at an address noted in the Certificate of Coverage.
- (C) The External Review decision shall be rendered by the Independent Review Organization within 21 days after receipt of the request by the Plan. An extension of up to 14 days is permitted if agreed to by both the Participant and the Plan. A participant may request that an appeal be expedited if the Participant is hospitalized or if the normal 21 day timeframe would place the Participant's life at risk. If expedited, the decision shall be made within 24 hours. An extension of up to 24 hours is permitted if the Participant and the Plan agree. If the decision of the Independent Review Organization is in favor of the Participant, the Plan must comply with the decision.
- (D) A Participant requesting External Review shall be assessed a \$25 filing fee that is to be paid to the Independent Review Entity and shall be refunded to the Participant if the final decision is in favor of the Participant. If a Participant is unable to pay the filing fee, the Participant shall request a waiver of the filing fee in writing to the Plan. The cost of External Review shall be paid by the Plan. If the Plan decides that a Participant is not eligible for an External Review and the Participant disagrees, the Participant may file a complaint with the Kentucky Department of Insurance. The Department of Insurance will render a decision within five days. A Participant with questions about the External Review process may contact the Appeals Department of the Provider or the Plan.

DEFINITIONS

Services defined here are not necessarily Covered Services. Refer to the Covered Services and Exclusions sections.

ACCIDENTAL INJURY OR ACCIDENTALLY INJURED - A sudden or unforeseen result of an external agent or trauma, independent of illness, which causes injury, including complications arising from that injury, to the body, and which is definite as to time and place.

ACUTE - The sudden onset of an unexpected illness or injury.

ADMISSION - Entry into a UK-HMO Participating Hospital including the UK Chandler Hospital as an inpatient in accordance with the rules and regulations of that facility.

ALTERNATE RECIPIENT - Any child of a Member who is recognized under a Qualified Medical Child Support Order as having a right to enrollment under the UK Medical Benefits Plan with regard to such Member.

ADVERSE DETERMINATION - A determination by an insurer or its designee that the health care services furnished or proposed to be furnished to a Member are:

1. Not Medically Necessary, as determined by the Plan, or its designee, or experimental or investigational, as determined by the Plan, or its designee; and
2. Benefit coverage is therefore denied, reduced, or terminated.

An Adverse Determination does not mean a determination by the Plan that the services furnished or proposed to be furnished are specifically limited or excluded in the benefit plan.

AMBULANCE - A certified vehicle for transporting ill or accidentally injured people that contains all life saving equipment and staff as required by state and local laws.

AMBULATORY SURGICAL CENTER - A Provider who:

1. has permanent facilities and equipment for the primary purpose of performing surgical and/or medical procedures to an Outpatient,
2. provides treatment by or under the supervision of Physician(s) and nursing services whenever the patient is in the facility,
3. does not provide accommodations to Inpatients, and
4. is licensed as a surgical center and is eligible for reimbursement by Medicare as a surgical center.

AUTISM - A condition affecting a Member which includes:

A. A total of six (6) or more items from subparagraphs 1, 2, and 3 of this paragraph, with at least two (2) from subparagraph 1 and one (1) each from subparagraphs 2 and 3:

1. Qualitative impairment in social interaction, as manifested by at least two (2) of the following:
 - (a) Marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction;
 - (b) Failure to develop peer relationships appropriate to developmental level;
 - (c) A lack of spontaneous seeking to share enjoyment, interests, or achievement with other people; or
 - (d) Lack of social or emotional reciprocity.
2. Qualitative impairments in communication as manifested by at least one (1) of the following:
 - (a) Delay in, or total lack of, the development of spoken language;
 - (b) In individuals with adequate speech, marked impairment in the ability to imitate or sustain a conversation with others;
 - (c) Stereotyped and repetitive use of language or idiosyncratic language; or
 - (d) Lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental levels.
3. Restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one (1) of the following:
 - (a) Encompassing preoccupation with one (1) or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus;
 - (b) Apparently inflexible adherence to specific, nonfunctional routines or rituals;
 - (c) Stereotyped and repetitive motor mannerisms; or
 - (d) Persistent preoccupation with parts of objects.

B. Delays or abnormal functioning in at least one (1) of the following areas, with onset prior to age three (3) years:

1. Social interaction;
2. Language as used in social communication; or
3. Symbolic or imaginative play.

C. The disturbance is not better accounted for by Rett's Disorder or Childhood Disintegrative Disorder.

D. A member age two (2) through twenty-one (21).

CARRIER - A health maintenance organization, insurer or entity which has been issued a certificate of authority by the Kentucky Office of Insurance.

CERTIFICATE OF COVERAGE OR CERTIFICATE - This document which lists definitions, covered services, exclusions and other provisions of coverage with the Plan.

CERTIFIED SURGICAL ASSISTANT - A certified surgical assistant or certified first assistant who is certified by the National Surgical Assistant Association on the Certification of Surgical Assistants, the Liaison Council on Certification of Surgical Technologists, or the American Board of Surgical Assistants. The certified surgical assistant is an unlicensed healthcare provider who is directly accountable to a physician licensed under KRS Chapter 311 or, in the absence of a physician, to a registered nurse licensed under KRS Chapter 314.

CHEMICAL DEPENDENCE - This term includes: (1) alcoholism; or (2) dependence, addiction or abuse of (a) alcohol; (b) chemicals; or (c) drugs.

CHEMICAL DEPENDENCE TREATMENT FACILITY - A Provider which is primarily engaged in providing detoxification and acute rehabilitation treatment for chemical dependence and does not primarily provide Custodial Care. The facility must be operated and licensed in accordance with the laws of the jurisdiction in which it is located and provides treatment by or under the care of Physicians and nursing services whenever the patient is in the facility.

CHILD OF SPONSORED DEPENDENT: Children of either you or your Sponsored Dependent may be covered under any of the benefit programs if they meet the guidelines that have been established by the plan noted below:

- Shares primary residence with UK-covered employee and Adult-Sponsored Dependent and has lived with UK employee at least twelve months prior to effective date of coverage.
- Is under the age of 26
- Is the natural born or adopted child of Adult-Sponsored Dependent
- Is unmarried
- Is not a relative of the covered UK employee (see the definition of relative above)

CHRONIC CONDITION - Any condition for which a Member receives ongoing care and treatment which may be provided on an intermittent basis.

COINSURANCE - The percentage of the Eligible Expense for a Covered Service that must be paid by the Member as specified in the Schedule of Benefits. Not all services require Coinsurance.

CONCURRENT REVIEW - The evaluation of a continued hospital stay to determine if services rendered meet established Medical Necessity criteria and are provided at the appropriate level of care.

CONTRACT - This Certificate, with the Group Contract and all attachments, any applicable riders, and the individual enrollment forms and questionnaires, if any, completed by the Members and Group, constitute the entire Contract between the parties.

CO-PAYMENT - A specified amount, indicated on the Schedule of Benefits, which the Member must pay at the time services are rendered for certain Covered Services. All services received during a Provider office visit (same site) are covered by the payment of a single Co-payment, except for allergy serum and allergy injections.

COVERAGE DENIAL - An insurer's determination that a service, treatment, drug, or device is specifically limited or excluded under the Member's benefit Plan.

COVERED SERVICE - A service or supply that is available under this Plan when the service is Medically Necessary and obtained in full compliance with all Plan rules. A charge for a Covered Service shall be considered to have been incurred on the date the service or supply was provided.

CREDITABLE COVERAGE - Prior coverage by a Member under any of the following:

1. A group health plan, including church and governmental plans;
2. Health insurance coverage;
3. Part A or Part B of Title XVIII of the Social Security Act (Medicare);
4. Medicaid, other than coverage consisting solely of benefits under section 1928;
5. The health plan for active military personnel, including CHAMPUS;
6. The Indian Health Service or other tribal organization program;
7. A state health benefits risk pool;
8. The Federal Employees Health Benefits Program;
9. A public health plan as defined in federal regulations;
10. A health benefit plan under section 5(e) of the Peace Corps Act; and
11. Any other plan which provides comprehensive hospital, medical, and surgical services.

CREDITABLE COVERAGE (cont.)

Creditable Coverage does NOT include any of the following:

1. Accident only coverage, disability income insurance, or any combination thereof;
2. Supplemental coverage to liability insurance;
3. Liability insurance, including general liability insurance and automobile liability insurance;
4. Workers compensation or similar insurance;
5. Automobile medical payment insurance;
6. Credit-only insurance;
7. Coverage for on-site medical clinics;
8. Benefits if offered separately:
 - Limited scope dental and vision;
 - Long-term care, nursing home care, home health care, community-based care, or any combination thereof;
 - Other similar, limited benefits.
9. Benefits if offered as independent, non-coordinated benefits:
 - Specified disease or illness coverage; and
 - Hospital indemnity or other fixed indemnity insurance.
10. Benefits if offered as a separate policy:
 - Medicare Supplement insurance;
 - Supplemental coverage to the health plan for active military personnel, including CHAMPUS; and
 - Similar supplemental coverage provided to group health plan coverage.

CUSTODIAL CARE - Care provided primarily for maintenance of the Member or which, as determined by the Plan, assists the Member in meeting activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an illness, disease, Accidental Injury, or condition. Custodial Care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets and supervision over self-administration of medications not requiring constant attention of trained medical personnel. Care or services provided to maintain a Member's condition at its current level of function is Custodial Care. Care that may be safely provided by family members and does not require the presence of trained medical personnel is Custodial Care.

DENTAL INJURY - An injury caused by a sudden, violent, and external force that could not be predicted in advance and could not be avoided. Dental injury does not include chewing injuries.

DEPENDENT - A person other than the Subscriber, more specifically defined as:

- A. The Subscriber's spouse under a legally valid existing marriage;
- B. The Subscriber's Sponsored Dependent: Sponsored Dependent is a dependent meeting the following criteria:
 - Shares primary residence with Subscriber(UK employee)and has lived with Subscriber for at least 12 months
 - Is not at least age of majority
 - Is not a relative. Definition of relatives: Parents, children, husbands, wives, brothers, sisters, brothers and sisters -in-law, mothers and fathers -in-law, uncles, aunts, cousins, nieces, nephews, great nieces, great nephews, grandchildren, great grandchildren, grandparents, great grandparents, sons or daughters -in-law, and half or step-relatives in the same relationships.
 - Is not employed by Subscriber
 - Is not eligible for Medicare
- C. The Subscriber's unmarried children from birth to age 26;
- C. For the purpose of determining eligibility for Dependent coverage, the term child or children includes
 - natural children, including newborn children
 - stepchildren by a legal marriage
 - children legally placed for adoption, and legally adopted children of the Member
 - children for whom legal guardianship has been awarded, and
 - children eligible to be claimed as Dependents on the Subscriber's federal income tax return.
 - child of a Sponsored Dependent who have been living with you for 12 months.

Also classified as a Dependent child is a child whom the Subscriber or the Subscriber's spouse has a legal obligation under a divorce decree or other court order to provide for the health care expenses of the child

DEPENDENT (cont.)

- D. Eligibility may continue past the age limit for an unmarried child who has been continuously covered under this Plan (or another health plan) since prior to the child reaching the age limit
- who is totally disabled and unable to work to support himself due to mental illness or retardation or physical handicap that started before the age limit, and
 - where the disability is medically certified by a Physician. The Plan may require proof of such Dependent's disability from time to time. A total disability is defined as the condition that results when any medically determinable physical or mental condition prevents a Dependent from engaging in substantial gainful activity and can be expected to result in death or to be of continuous or indefinite duration and is approved by the Plan.

DIAGNOSTIC ADMISSION - An admission of an Inpatient that does not require the constant availability of medical supervision or Skilled Nursing Care to monitor a condition. The primary purpose of such admission is to arrive at a diagnosis through the use of x-ray and laboratory tests, consultations, and evaluation, as documented by the Hospital's medical records.

DIAGNOSTIC SERVICE - A test or procedure rendered because of specific symptoms and which is directed toward the determination of a definite condition or disease. A Diagnostic Service must be ordered by a Participating Physician or other professional Provider.

DURABLE MEDICAL EQUIPMENT - Equipment the Plan determines to be: (a) designed and able to withstand repeated use; (b) used primarily for medical purposes; (c) mainly and customarily used to serve a medical purpose; and (d) suitable for use in the home.

EFFECTIVE DATE - The date on which coverage for a Member begins.

ELIGIBLE EXPENSE - The fee schedule adopted by the Plan and used for the purpose of Coinsurance calculation. Also referred to as the allowable amount.

EMERGENCY MEDICAL CONDITION -

- A. A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson would reasonably have cause to believe constitutes a condition that in the absence of immediate medical attention could reasonably be expected to result in:
 1. Placing the Member's health in serious jeopardy, or in the case of a pregnant woman, placing the health of the woman or her unborn child, in serious jeopardy;
 2. Causing serious impairment to bodily functions; or
 3. Causing serious dysfunction of any body organ or part.
- B. With respect to a pregnant woman who is having contractions:
 1. A situation in which there is inadequate time to effect a safe transfer to another Hospital before delivery; or
 2. A situation in which transfer may pose a threat to the health or safety of the woman or the unborn child.

EMPLOYEE - (see subscriber)

EMPLOYEE + CHILD(ren) COVERAGE - Coverage for the Subscriber and eligible Dependents except the spouse.

EMPLOYEE + FAMILY COVERAGE - Coverage for the Subscriber, a spouse and one or more eligible covered Dependents.

EMPLOYEE + SPOUSE COVERAGE - Coverage for the Subscriber and his or her legal spouse.

EXPERIMENTAL OR INVESTIGATIONAL SERVICES - Services or supplies, including treatments, procedures, hospitalizations, drugs, biological products or medical devices, which the Plan determines are: (a) not of proven benefit for the particular diagnosis or treatment of the Member's particular condition; or (b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of the Member's particular condition; or (c) provided or performed in special settings for research purposes or under a controlled environment or clinical protocol. Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the United States Food and Drug Administration (FDA), the Plan will not cover any services or supplies, including treatment, procedures, drugs, biological products or medical devices or any hospitalization in connection with Experimental or Investigational services or supplies. The Plan will also not cover any technology or any hospitalization in connection with such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of the Member's particular condition. Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of the particular condition as explained below.

EXPERIMENTAL OR INVESTIGATIONAL SERVICES (cont.)

The Plan will apply the following five criteria in determining whether services or supplies are Experimental or Investigational. All five criteria must be met:

1. Any medical device, drug, or biological product must have received final approval to market by the United States Food and Drug Administration (FDA) for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition will require that one or more of the following established reference compendia: The American Medical Association Drug Evaluations; The American Hospital Formulary Service Drug Information; or The United States Pharmacopoeia Drug Information recognize the usage as appropriate medical treatment.
As an alternative to such recognition in one or more of the compendia, the usage of the drug will be recognized as appropriate if it is recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal. A medical device, drug, or biological product that meets any of the above tests will be considered to have met this criterion. In any event, any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental or Investigational;
2. Conclusive evidence from the published peer-review medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;
3. Demonstrated evidence as reflected in the published peer-review medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;
4. Proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and
5. Proof as reflected in the published peer-reviewed medical literature must exist that improvement in health outcomes, as defined above in criterion 3, is possible in standard conditions of medical practice, outside clinical investigatory settings.

FREESTANDING RENAL DIALYSIS FACILITY - A Provider other than a Hospital which is primarily engaged in providing renal dialysis treatment, maintenance or training to Outpatients and is eligible for reimbursement from Medicare.

HEARING AID AND RELATED SERVICES - Any wearable, non-disposable instrument or device designed to aid or compensate for impaired human hearing and any parts, attachments, or accessories, including earmolds and those services necessary to assess, select, and appropriately adjust or fit the hearing aid to ensure optimal performance, excluding batteries and cords.

HOME HEALTH AGENCY - An agency that provides intermittent skilled nursing and health related services to Members in their home under a plan prescribed by a Physician. The agency must be licensed as a Home Health Agency by the state in which it operates, and be certified to participate in Medicare as a Home Health Agency.

HOSPICE - A Provider, other than a facility that treats Inpatients, which is primarily engaged in providing pain relief, symptom management, and supportive services to terminally ill persons and their families. The facility must be operated in accordance with the laws of the jurisdiction in which it is located.

HOSPITAL - A licensed acute care institution engaged in providing medical care and treatment to a patient as a result of illness, accident or mental disorder on an Inpatient or Outpatient basis at the patient's expense and which fully meets the following:

1. It is a Hospital accredited by the Joint Commission on the Accreditation of Healthcare Organizations, the American Osteopathic Association or the Commission on the Accreditation of Rehabilitative Facilities, or certified by the Kentucky Cabinet for Health Services Division of Licensure and Regulation;
2. It maintains diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of patients under the supervision of a staff of fully licensed Physicians. However, no claim for payment of treatment care or services shall be denied because a Hospital lacks major surgical facilities and is primarily of a rehabilitative nature, if such rehabilitation is specifically for treatment of physical disability; and
3. It continuously provides twenty-four (24) hours a day nursing service by or under the supervision of registered graduate nurses.

HUMANA - A licensed Third Party Administrator (TPA) that is contracted to provide administrative services to UK-HMO Members and to provide access to its provider network in the Service Area. This is sometimes referred to as the Plan.

INPATIENT - A Member who is treated as a registered bed patient in the UK Chandler Hospital or other institutional Provider and for whom a room and board charge is made.

KENTUCKY CLINIC - A facility of the UK Chandler Hospital providing Outpatient care through primary and specialty clinics for diagnostic and therapeutic services. Outpatient care support services, such as a pharmacy, radiology and diagnostic laboratory are also located within the Kentucky Clinic.

LIVE OR RESIDE - The location where the Member resides for a majority of the Plan Year with the intention of making the Member's home there and not for a temporary purpose. Temporary absences from Kentucky, with the intent to return will not interrupt the Member's status as living in Kentucky.

MEDICALLY NECESSARY OR MEDICAL NECESSITY - The services or supplies furnished by a Participating Provider within the LSA Service Area or referred services that are required to identify or treat a Member's illness or injury and which, as determined by the Plan, meet all four of these criteria:

1. consistent with the symptom or diagnosis and treatment of the Member's condition, disease, ailment, or injury;
2. appropriate with regard to standards of good medical practice;
3. not solely for the convenience of a Member or Provider; and
4. the most appropriate supply or level of service which can be safely provided to the Member.

When applied to the care of an Inpatient, it further means that the Member's medical symptoms or condition require that the services cannot be safely provided as an Outpatient.

For determining the "most appropriate level of service" the Plan may take into account the cost of the proposed service with respect to other medically appropriate treatments.

MEMBER - An individual eligible for coverage with the Group who meets all eligibility requirements. The term "Member" includes any such individual whether referred to as a "Insured," "Subscriber," "Dependent," "you" or otherwise.

MENTAL HEALTH CONDITION - A condition that manifests symptoms which are primarily mental or nervous, regardless of any underlying physical cause. A Mental Health Condition includes, but is not limited to, psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders, Attention Deficit Disorder, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems. Some Mental Health Conditions are excluded from coverage. In determining whether or not a particular condition is a Mental Health Condition, the Plan may refer to the current edition of the Diagnostic and Statistical Manual of Mental Conditions of the American Psychiatric Association, or the International Classification of Diseases (ICD) Manual.

NETWORK - All Participating Providers within the University of Kentucky Lexington Service Area.

NON-PARTICIPATING PROVIDER - Any Provider other than a UK Participating Provider. You will be responsible for the entire amount of the non-participating provider's charges, except for emergency care or services authorized in advance by the Plan.

NURSING FACILITY - A Provider which is primarily engaged in providing Skilled Nursing Care and related services to an Inpatient requiring convalescent and rehabilitative care. Such care is rendered by or under the supervision of a Physician and eligibility for payment is based on care rendered in compliance with Medicare-established guidelines. The facility must be operated in accordance with the laws of the jurisdiction in which it is located. A Nursing Facility is not, other than incidentally, a place that provides:

1. minimal care, Custodial Care, ambulatory care, or part-time care services, and
2. care or treatment of Mental Health Conditions, alcoholism, drug abuse or pulmonary tuberculosis.

OPEN ENROLLMENT - A period of time at least once each calendar year established by the University when eligible employees may enroll or dis-enroll themselves and their eligible Dependents in the Plan.

ORGAN TRANSPLANT - A procedure or operation to transfer a human organ from one body or body part to another. Organ in this Certificate means heart, kidney, liver, lung, pancreas (covered only in combination with a covered kidney transplant), blood precursor cells and marrow. (Cornea tissue transplants are also covered under the Plan terms and conditions for hospital and surgical benefits, including Prior Plan Approval, but are not subject to the additional requirements specific to Organ Transplants).

OUTPATIENT - A Member who receives covered services, referred services or supplies while not an Inpatient.

OUTPATIENT SURGERY - A therapeutic procedure performed in a facility and for which an overnight stay is not required.

PARTICIPATING PROVIDER - Any UK Participating Provider or other Provider with whom we have a written contract for providing Hospital, surgical, and medical services or supplies. Member responsibility is limited to Co-payments, Coinsurance amounts, and charges for non-covered services, if any. Refer to on-line provider directory for a list of Providers who contract with the Plan. This network can be accessed at www.humana.com/tools and choosing the provider type on the bottom right side of the page. Providers are subject to change without notice.

PARTICIPATING PRIMARY CARE PHYSICIAN - A duly licensed UK Medical Center Provider who is a practitioner specializing in family practice, general practice, internal medicine, or pediatrics who supervises, coordinates and provides initial care and basic medical services to a Member; recommends specialty services; and is responsible for maintaining continuity of patient care.

PARTICIPATING SPECIALIST PHYSICIAN - A duly licensed UK Medical Center Physician who specializes in diagnosing and treating a class of disease after an advanced formal clinical program pertaining to all aspects of this disease process. Participating Specialist Physicians are listed in the UK-HMO Provider Directory. You can also find a searchable provider directory on the Web site at www.mc.uky.edu/ukhmo.

PHYSICIAN - Any Doctor of Medicine or Doctor of Osteopathy who is licensed and legally entitled to practice medicine, perform surgery, and dispense drugs.

PHYSICIAN ASSISTANT - A person who has graduated from a physician assistant or surgeon assistant program accredited by the Accreditation Review Commission on Education for Physician Assistants or its predecessor or successor agencies and has passed the certifying examination administered by the National Commission on Certification of Physician Assistants or its predecessor or successor agencies, or possesses a current physician assistant certificate issued by the board prior to July 15, 2002.

PLAN - Refers to Third Party Administrator (Humana).

PLAN DELIVERY SYSTEM RULES - The Plan's specific procedures that must be followed to obtain benefits for Covered Services. Refer to the Plan Delivery System Rules section beginning on page 6.

PLAN YEAR - Each successive twelve (12) month period beginning July 1st.

PREMIUM - The amount of money prepaid monthly to the UK Medical Benefits Plan by the Subscriber and/or the University to maintain coverage.

PRIMARY RESIDENCE - The location where the Member lives for a majority of the Plan year. Temporary absences from the Service Area with the intent to return within 120 days will not interrupt the Member's primary residence in the Service Area. Members experiencing absences from the service area for a period of 121 days, regardless of intent to return, are required to contact UK Employee Benefits to make arrangements for enrolling in an alternative benefit structure.

PRIOR PLAN APPROVAL OR PPA - The process where by the Plan reviews certain services in advance of the delivery of the service. Prior Plan Approval review includes the determination of benefit coverage as described in this Certificate of Coverage and the appropriateness of the proposed service with respect to Medical Necessity Criteria developed or adopted by the Plan.

PROVIDER - A facility or person, including the UK Chandler Hospital, or UK Medical Center Physician, which is licensed, where required, to render Covered Services. Providers other than a Hospital or Physician include:

- Ambulatory Care Facility
- Birth Center
- Freestanding Renal Dialysis Facility
- Home Health Agency
- Hospice
- Psychiatric Facility
- Skilled Nursing Facility
- Rehabilitative Facility
- Substance Abuse Treatment Facility
- Registered Nurse Practitioner
- Doctor of Chiropractic
- Doctor of Dental Medicine
- Doctor of Dental Surgery
- Doctor of Optometry
- Doctor of Osteopathy
- Doctor of Podiatry

PROVIDER – (cont.)

Doctor of Surgical Chiropody
 Licensed Dietician
 Licensed Psychologist
 Licensed Clinical Social Worker
 Licensed Physical Therapist
 Licensed Practical Nurse
 Licensed Speech Pathologist
 Licensed Speech Therapist
 Licensed Occupational Therapist
 Licensed Pharmacist
 Licensed Advanced Registered Nurse Practitioner
 Midwife
 Registered Nurse
 Registered Nurse First Assistant
 Regulated Physician Assistant
 Respiratory Therapist
 Certified Psychologist
 Certified Psychological Associate
 Certified Surgical Assistant
 Ophthalmic Dispenser
 Ambulance Service
 Supplier of Durable Medical Equipment, Prosthetic appliances or Orthotic device

PROVIDER NETWORK - consists mainly of the facilities at the University of Kentucky including UK Chandler Hospital; UK Good Samaritan Hospital; as well as the UK providers. There are some ancillary providers located in the other LSA counties for services not provided at UK. These can be found in the on-line provider network at www.humana.com/tools and choosing the type of provider at the bottom right of the page and searching the UK-HMO LSA network.

PSYCHIATRIC FACILITY - A Provider, appropriately licensed and certified, primarily engaged in providing diagnostic and therapeutic services for the treatment of Mental Health Conditions. The facility must be operated in accordance with the laws of the jurisdiction in which it is located and provide treatment by or under the care of Physicians and nursing services whenever the patient is in the facility.

QUALIFIED MEDICAL CHILD SUPPORT ORDER ORQMCSO - A court order which establishes the right of an Alternate Recipient to receive benefits for which a Member is eligible under the UK Medical Benefits Plan. The QMCSO must clearly specify: the name and mailing address of the Member as well as the name and mailing address of each Alternate Recipient covered by the order; a reasonable description of the type of coverage to be provided; and the period covered by the court order.

RESPIRE CARE - Care which is necessary to provide temporary relief from care giving responsibilities, to support caregivers who are actively involved in providing the care required by a Member, and whose continuing support is necessary to maintain the individual at home.

SERIOUS MENTAL CONDITION or SIGNIFICANT BEHAVIORAL PROBLEM - A condition:

- A. Identified by a diagnostic code from the most recent edition of the:
 1. International Classification of Diseases-Clinical Modification, including only diagnosis codes ranging from 290 through 299.9, 300 through 316, and 317 through 319; or
 2. Diagnostic and Statistical Manual of Mental Disorders; and
- B. In a person whose:
 1. Inability to cooperate during dental care by a dentist performed in a location other than a hospital or ambulatory surgical facility can reasonably be inferred from the person's diagnosis and medical history; or
 2. Airway, breathing, or circulation of blood may be compromised during dental care by a dentist performed in a location other than a hospital or ambulatory surgical facility.

This definition only applies to the dental anesthesia and facility benefit services.

SERIOUS PHYSICAL CONDITION - A disease or condition requiring ongoing medical care that may cause compromise of the airway, breathing or circulation of blood during dental care by a dentist performed in a location other than a hospital or ambulatory surgical facility. This definition only applies to the dental anesthesia and facility benefit services.

SERVICE AREA - The geographic area approved by state regulatory authorities, which is served specific to this UK-HMO benefit structure consists of the following Kentucky Counties: Anderson, Bourbon, Clark, Fayette, Franklin, Jessamine, Madison, Mercer, Scott or Woodford.

SINGLE COVERAGE - Coverage for the employee/subscriber only.

SKILLED NURSING CARE - Care needed for medical conditions which require care by licensed medical personnel such as registered nurses or professional therapists. Care is available 24 hours per day, is ordered by a Physician, and involves a treatment plan.

SPECIAL ENROLLMENT PERIOD - A period of time during which an eligible person or Dependent who loses other coverage or incurs a change in his or her family status may enroll in the Plan without being considered a Late Enrollee.

SPONSORED DEPENDENT - The University of Kentucky offers you the opportunity to cover a Sponsored Dependent under your health benefit program. A Sponsored Dependent is defined as a person other than the Subscriber, more specifically defined as:

- At least the age of majority
- Not a relative. Definition of relatives: Parents, children, husbands, wives, brothers, sisters, brothers-and sisters-in law, mothers- and fathers-in law, uncles, aunts, cousins, nieces, great nieces, nephews, great nephews, grandmothers, grandfathers, great grandmothers, great grandfathers, sons-and daughters-in law and half- or step-relatives of the same relationships. *Note: Children for whom the employee has legal guardianship continue to be eligible for the current Medical Benefits Plan.*
- Not employed by the UK employee
- Not eligible for Medicare

CHILDREN OF SPONSORED DEPENDENTS:

- Shares primary residence with UK-covered employee and Adult-Sponsored Dependent and has lived with UK employee at least twelve months prior to effective date of coverage.
- Is under the age of 26
- Is the natural born or adopted child of Adult-Sponsored Dependent
- Is unmarried
- Is not a relative of the covered UK employee (see the definition of relative above)

SUBROGATION - The term “Allowed Amount” as in this Section shall mean the amount which UK-HMO paid for the Covered Services, subject to the following rules:

- A. When UK-HMO or Humana has a contract with a Participating Provider under which the Participating Provider has agreed to accept a traditional fee-for-service payment, “Allowed Amount” means that payment. Under these circumstances, the Allowed Amount will not take into account any additional payments, reductions, or withholdings which are applicable as a result of any incentive or risk-sharing arrangements with the Participating Provider.
- B. When UK-HMO or Humana has a contract with a Participating Provider under which the Participating Provider has agreed to an alternative reimbursement arrangement (such as capitation) that does not base reimbursement on traditional fee-for-service payments, then “Allowed Amount” means the provider’s usual charge for the service.
- C. When UK-HMO pays a provider that is not a Participating Provider, “Allowed Amount” means the reimbursement paid to the provider.

SUBSCRIBER - An employee eligible for coverage with the Group who meets all eligibility requirements.

SUBSTANCE ABUSE TREATMENT FACILITY - A Provider which is primarily engaged in providing detoxification and rehabilitation treatment for chemical dependence. The facility must be operated and licensed in accordance with the laws of jurisdiction in which it is located and provides treatment by or under the care of Physicians and Nursing Services whenever the Member is in the facility.

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

THERAPY SERVICE - Services or supplies used for the treatment of an acute illness or Accidental Injury to promote the recovery of the patient. Therapy services include but are not limited to:

1. Physical Therapy - The treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, biomechanical and neurophysiological principles, and devices to relieve pain, restore maximum function, and prevent disability following disease, Accidental Injury, or loss of a body part.
2. Respiratory Therapy - Introduction of dry or moist gases into the lungs for treatment purposes.
3. Speech Therapy - The treatment rendered to restore acute speech loss due to illness or Accidental Injury to the mechanisms of speech.

THERAPY SERVICE (cont.)

4. Cardiac Rehabilitation - Cardiac rehabilitation (rehab) is a medically supervised program that helps improve the health and well-being of people who have heart problems. Rehab programs include exercise training, education on heart healthy living, and counseling to reduce stress and help you return to an active life. ***If a member completes 24 or more cardiac rehab treatments, UK-HMO will reimburse members for 50% of their cardiac rehab co-payments. See cardiac rehab provider for reimbursement form to submit.***
5. Occupational Therapy - The treatment program of prescribed activities, emphasizing coordination and mastery, designed to assist a person to regain independence, particularly in the normal activities of daily living.
6. Chiropractic Manipulative Therapy - A form of manual treatment to influence joint and neuro physiologic function, and may be accomplished by various techniques.
7. Osteopathic Manipulative Therapy - This treatment is a form of manual treatment applied by a specially trained Physician to eliminate or alleviate somatic dysfunction and related disorders.
8. Acupuncture Therapy - This treatment is a Chinese medical practice that involves the insertion of hair-fine needles into nonanatomic energy channels, called meridians performed by a specially trained Physician. Acupuncture is only covered when services are provided by an medical doctor (M.D.).
9. Pool Therapy/Exercise Hydrotherapy - A physical therapy modality that involves the therapeutic use of water to treat a number of conditions under the supervision of a medically trained professional.
10. Pulmonary Rehabilitation - Pulmonary Rehabilitation is a program of education and exercise classes that teach a member about their lungs, how to exercise and do activities with less shortness of breath, and how to "live" better with their lung condition. ***If a member completes 24 or more pulmonary rehab treatments, UK-HMO will reimburse members for 50% of their pulmonary rehab co-payments. See pulmonary rehab provider for reimbursement form to submit.***

THIRD PARTY ADMINISTRATOR or TPA - A corporate entity (third party) that administers Group benefits, claims, and administration for a self-funded company and for the purposes of this Certificate is Humana.

TOTAL DISABILITY or TOTALLY DISABLED - The Member's continuing inability as a result of injury or illness to perform the material and substantial duties of any occupation for which he or she is suited by reason of education, training or experience. If not employed, Total Disability means the Member's continuing inability to engage in the normal activities of daily living for a person of like age and gender as a result of injury or sickness.

UK CHANDLER HOSPITAL PHYSICIAN -A duly licensed doctor of medicine or doctor of Osteopathy under contract with the University of Kentucky.

UK-HMO - A benefit structure and provider network available to the University of Kentucky employees and their Dependents through the University's self-insured program. As a self-insured product, it is not a licensed HMO. For the purposes of this Certificate, UK-HMO refers to UK Health Care Plans or its designated TPA, also referred to as the Plan.

UK CHANDLER HOSPITAL - The institutions that are comprised of UK HealthCare Chandler Medical Center; UK HealthCare Good Samaritan Hospital; five health profession colleges (Colleges of Medicine, Dentistry, Nursing, Pharmacy and Allied Health Professions), the Lucille Parker Markey Cancer Center, Sanders-Brown Center on Aging, Kentucky Clinic, Kentucky Clinic North, Kentucky Clinic South, UK HealthCare East and the UK Center for Rural Health.

UNIVERSITY OF KENTUCKY MEDICAL BENEFITS PLAN OR UK MEDICAL BENEFITS PLAN –

The University's Group Health Insurance plan for employees, retirees and their Dependents in which the University assumes the financial risk of paying for all Covered Services provided to enrollees.

URGENT CARE - Services, supplies, or other care that is appropriate to the treatment of an illness or injury that is not a life-threatening emergency, but requires prompt medical attention. Urgent care includes the treatment of minor injuries as a result of accidents, the relief or elimination of severe pain, or the moderation of an acute illness.

COVERED SERVICES

Subject to the applicable limitations, Exclusions, Delivery System Rules, medical PPA process, and other conditions of the UK Health Care Plan, Members are entitled to the benefits as described in this Covered Services Section under this benefit plan. Except for Emergency Care, you must obtain Covered Services from UK HealthCare (UK Chandler Medical Center, UK Kentucky Clinics or UK Chandler Medical Center Physicians) for services to be covered.

Benefits will be provided only for services, supplies and care that are Medically Necessary and consistent with the diagnosis and treatment of a covered illness or injury, in the amounts specified in the Schedule of Benefits. Benefits will be denied for failure to follow the Plan's Delivery System Rules.

Review the Plan's Delivery System Rules carefully. Refer to the Schedule of Benefits section for the amount of benefits payable, limitations and maximums under your Certificate. Refer to the Exclusions section of this Certificate for information on conditions and services that are permanently excluded from coverage under this Plan regardless of Medical Necessity.

1. HOSPITAL SERVICES

A. INPATIENT HOSPITAL SERVICES - Unless otherwise excluded, benefits are provided for the following services rendered to an Inpatient at a Participating Hospital. The services must be ordered by your Participating Physician and authorized in advance by the Plan. No benefits are provided for services rendered at a Hospital other than the UK Chandler Hospital, unless prior approval is obtained from the Plan, or for Emergency Care when out of the service area.

1. Room and board when the Member occupies:
 - a. A room with two or more beds, known as a semi-private room or ward; or
 - b. A private room. The private room allowances shall be limited to an amount equal to the Hospital's average semi-private rate. In cases of a facility which only has private rooms, then the average semi-private rate does not apply; or
 - c. A private room for the distinct purpose of medical isolation. Coverage is limited to the period of time for which medical isolation is Medically Necessary. Such cases require specific approval by the Plan; or
 - d. A bed in a special care unit, including nursing services, which is approved by the Plan and has concentrated facilities, equipment, and supportive services for the provision of an intensive level of care for critically ill patients.
2. Ancillary Services and supplies including, but not restricted to:
 - a. Use of operating, delivery, and treatment rooms and equipment;
 - b. Prescription drugs administered to an Inpatient;
 - c. Administration of blood and blood processing;
 - d. Anesthesia supplies and services rendered by an employee of the Hospital or through approved contractual arrangements;
 - e. Medical and surgical dressings, supplies, casts, and splints;
 - f. Diagnostic Services;
 - g. Therapy Services; and
 - h. Special care unit nursing services, other than the portion payable under I(A)(1)(d) above.
 - i. Radioisotopes and radium.
 - j. Skin, bone, and tissue bank expenses.

B. OUTPATIENT HOSPITAL, LICENSED AMBULATORY SURGICAL CENTER FACILITY, OTHER LICENSED FACILITY SERVICES

1. Surgery, which includes facility services, supplies, and anesthesia supplies. Services rendered by an employee or any contractor of the facility, other than non-employed Physicians and anesthesiologist(s), are included in the payment for facility services.
2. Ancillary services listed below and furnished to an Outpatient; some of these services require Prior Plan Approval:
 - a. Use of operating room and recovery rooms;
 - b. Respiratory therapy (e.g. oxygen);
 - c. Administered drugs and medicine;
 - d. Intravenous solutions;
 - e. Dressings, including ordinary casts, splints or trusses;
 - f. Anesthetics and their administration;
 - g. Transfusion supplies and equipment.

1. HOSPITAL SERVICES (continued)

- h. Factor 8 and 9 for blood clotting enhancements in relation to hemophilia, and gamma globulin;
- i. Diagnostic Services, including radiology, ultrasound, laboratory, pathology and approved machine testing, e.g., electrocardiogram (EKG);
- j. Chemotherapy treatment for malignant disease;
- k. Radiation therapy, treatment by x-ray, radium or radioactive isotopes; and
- l. Renal Dialysis Treatment for acute or chronic kidney ailment which may include the supportive use of an artificial kidney machine.

C. EMERGENCY CARE

Benefits are provided for treatment of Emergency Medical Conditions (EMC) and emergency screening and stabilization of an EMC without Prior Plan Approval for conditions that reasonably appear to a prudent layperson to constitute an EMC based upon the Member's presenting symptoms and conditions. Benefits for Emergency Care include facility costs, supplies, medicines, and Physician services. **Emergency Care must be rendered by a UK Participating Provider at the UK Chandler Hospital unless time or other circumstances make it impossible.** To assure coverage for Emergency Care, Members must comply with the following procedures:

- Members should call their Primary Care Physician or the Plan at the number on their ID card whenever practical.
- If it is not possible to call prior to seeking Emergency Care, the Member must notify the Plan within 24 hours, or the next business day, of the Emergency Care treatment or hospitalization if treated at a facility other than the UK Chandler Hospital or Outpatient Facility.

Care in Hospital emergency rooms is subject to the emergency room Co-payment on the Schedule of Benefits. The emergency room Co-payment will not be required if the Member is admitted as an Inpatient for the condition for which he or she sought emergency care. If admitted, the Inpatient Co-payment would then apply.

If a Member is admitted to a Non-Participating Hospital for stabilization of an Emergency Medical Condition, the Plan may require that the Member be transferred to a Participating Hospital as soon as medically feasible in order to receive In-Network benefits. A Member may also request that the Plan facilitate transfer to a Participating Hospital.

Benefits are not provided for the use of an emergency room except for treatment of an EMC, emergency screening and stabilization. All follow-up or continued care services or prescriptions must be provided by UK Participating Providers in accordance with Plan Delivery System Rules.

2. SURGICAL SERVICES

A. SURGERY

When performed by a Physician within the applicable scope of practice, coverage includes usual pre-operative and post-operative care. Coverage is provided for the services of a second Physician in the performance of certain covered surgical procedures. The Plan maintains a list of procedures for which a second Physician is Medically Necessary.

B. ASSISTANCE AT SURGERY

Coverage is provided for Medically Necessary services of an assistant at surgery who actively assists the surgeon in the performance of a covered surgical procedure. The assistant must be properly credentialed by the facility at which the surgery is performed and be a Physician, a Certified Surgical Assistant, a Registered Nurse First Assistant, or a Physician Assistant. The Plan maintains a list of procedures for which an assistant at surgery is Medically Necessary. No coverage is available for interns, residents, or facility house staff members who assist.

C. ANESTHESIA

Coverage is provided for the services of a Physician or Certified Registered Nurse Anesthetist other than the surgeon(s) for administration of anesthesia. Administration or supervision of anesthesia or conscious sedation by the surgeon or an assistant is covered as part of the global surgical fee and/or fees paid to the facility where the procedure is performed. No additional payment will be made for this service.

D. ELECTIVE STERILIZATION

Coverage is provided for Outpatient procedures performed for the sole purpose of elective sterilization.

2. SURGICAL SERVICES (Cont.)

E. RECONSTRUCTIVE SURGERY

Services, supplies or care incurred for reconstructive surgery: (a) when surgery is directly related to surgery for treatment of a traumatic injury or medical illness affecting the involved part, subject to exclusions; (b) because of congenital disease or anomaly of a Member which has already resulted in a functional defect (difficulty in activities of daily living); (c) all stages of breast reconstruction surgery and correction of breast size disproportion or dissymmetry following a mastectomy that resulted from breast disease; or (d) treatment of lymph edemas following a mastectomy.

F. COCHLEAR IMPLANTS

3. PROFESSIONAL CARE TO INPATIENTS

Coverage for maternity care is listed on page 34. Coverage for Mental Health Conditions is listed beginning on page 34. Benefits for medical care to Inpatients are limited to:

A. VISITS BY THE ATTENDING PHYSICIAN

B. INTENSIVE MEDICAL CARE

C. ACUTE MEDICAL DETOXIFICATION FOR ALCOHOL AND ADDICTIVE DRUGS

D. CONCURRENT MEDICAL CARE

1. Medical care in addition to surgery during the same admission for unrelated medical conditions this medical care is provided by a Physician other than the operating surgeon.
2. Medical care by two or more Physicians during the same admission for unrelated medical conditions. The medical care must require the skills of separate Physicians.

E. CONSULTATIONS

Consultations provided by a Physician at the request of the attending Physician. Consultations do not include staff consultations required by Hospital rules and regulations.

4. OUTPATIENT PROFESSIONAL SERVICES

A. Non-surgical medical care services rendered by a Participating Physician or other qualified Provider to a Member for the examination, diagnosis, or treatment of a covered illness or injury.

B. Medical care which is rendered concurrently by different Physicians may be considered for benefits if treatment is for separate medical conditions, or the nature or severity of the medical condition requires the skills of separate Physicians or other Providers. This includes the medical services rendered for the purpose of a consultation with the attending Physician, exclusive of staff consultations required by any facility rules or regulations.

C. Covered Services must be performed, delivered or supervised by a Participating Physician or other qualified Provider and must be performed in a manner consistent with prevailing medical standards.

5. PREVENTIVE CARE SERVICES

Preventive Care Services means care which is rendered by a Provider to prevent future health problems for a Member who does not exhibit any current symptoms. See your Schedule of Benefits for any limitations. Note: Preventive Care Services rendered by a Non-Participating Provider are not covered services.

Preventive Care Services include:

A. Routine Exams and Immunizations

1. Routine or periodic exams (e.g. pelvic exams).

Having the right exams at the right times may help you avoid serious illness. Check with your Provider for specific health guidelines based on your age and family history. Family history, current health problems and lifestyle all affect your risk for disease. Talk to your Provider to determine if you are at high risk for specific disease and then together determine your appropriate exam schedule.

Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes, are not covered.

5. PREVENTIVE CARE SERVICES (Cont.)

A. Routine Exams and Immunizations (Cont.)

2. Immunizations

Immunizations protect you from certain diseases and help prevent epidemics. While immunization risks to your health are low, the risks from disease are high. Both children and adults need immunizations to help keep them healthy. UK-HMO covers pediatric and adult immunizations, in accordance with recommendations of the Advisory Council on Immunization Practices of the Centers for Disease Control and Prevention as medically necessary, except as otherwise excluded in this Certificate.

3. Annual medical eye exams for diabetic retinopathy for members with diabetes.

B. Routine/Preventive Diagnostic Services

1. Well child periodic examinations, development assessments and anticipatory guidance necessary to monitor the normal growth and development of a child.

2. Annual adult physical exams, one per 12-month period; periodic early detection services, including cervical PAP smears; mammography; rectal/sigmoidoscopy; cardiac risk profile (blood test); PSA; serum glucose; and E.K.G.

3. Some preventive services require Prior Plan Approval (see page 9)

4. Routine bone density testing for women for women age 35 and older.

5. Routine colorectal screening

C. Diabetes Self-Management Training

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

- Medically Necessary
- Ordered in writing by a physician, and
- Provided by a Health Care Professional who is certified by the American Diabetes Association or is a Certified Diabetic Educator (CDE). A diabetes education session must be provided by a Health Care Professional in an outpatient facility or in a Physician's office. For the purposes of this provision, a "Health Care Professional" means the physician ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Associate or a Certified Diabetes Educator.

6. ALLERGY SERVICES

Medical care for allergy testing, preparation of serum, serum, and administration of injections.

7. AMBULANCE AND EMERGENCY MEDICAL TRANSPORTATION SERVICES

Benefits are limited to emergency medical services and supplies, ambulance services and supplies involving admissions for Inpatients or treatment of Outpatients for Emergency Medical Conditions.

A. Ambulance service providing local transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured:

1. From a Member's home or other place of Emergency Medical Condition to the closest facility that can provide Covered Services appropriate to the Member's condition. If there is no facility in the local area that can provide Covered Services appropriate to the Member's condition, ambulance service means transportation to the closest facility outside the local area that can provide the necessary services;
2. Between Hospitals; and
3. Between a Hospital and Nursing Facility, with Prior Plan Approval.

B. When approved by the Plan, ambulance or other flat transport service providing local transportation by means of a specially designed vehicle used only for transporting the sick and injured:

1. From a Hospital to the Member's home; or
2. From a Nursing Facility to the Member's home when the transportation to the facility would qualify as a Covered Service.
3. Air Ambulance, only if the Plan determines it is the only medically appropriate means of transportation to the nearest appropriate facility

8. DENTAL SERVICES

Dental services provided under this Plan are limited to only the following services. Refer to the Exclusions section for more information about non-covered dental services.

A. ACCIDENTAL INJURY

Extraction of a sound natural tooth lost due to a dental injury. The dental injury and replacement must occur while you are covered under the Plan. Services must begin within 7 days and be completed within 12 months after the date of the dental injury. Benefits will be paid only for expense incurred for the least expensive service that will, in the Plan Manager's opinion, produce a professionally adequate result.

B. ANESTHESIA AND FACILITY BENEFIT

Coverage is provided for general anesthesia and Hospital or ambulatory surgical facility charges in connection with dental problems for children below the age of nine (9) years, persons with Serious Mental or Physical Conditions, and persons with Significant Behavioral Problems, when certified by the treating dentist or admitting physician.

C. JAW JOINT PROBLEMS

Surgical or non-surgical treatment including but not limited to therapy, for any jaw joint problem including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder or other conditions of the joint linking the jaw bone and skull; surgical or non-surgical treatment of the facial muscles used in expression and mastication functions, for symptoms including but not limited to, headaches. Prior authorization is required. These expenses do not include charges for orthodontic services.

9. DIAGNOSTIC SERVICES

Diagnostic Services, including their interpretation, when provided by an appropriately trained Provider, for the treatment of an illness or injury may include but are not limited to:

- A. X-ray and other imaging services,
- B. Mammograms for Members who have been diagnosed with breast disease when ordered by any practitioner practicing within the scope of their license,
- C. Laboratory and pathology services, and
- D. Electrocardiogram (EKG), electroencephalogram (EEG) and polysomnography.

10. DURABLE MEDICAL EQUIPMENT

Coverage for Durable Medical Equipment includes, but is not limited to, apnea monitors, breathing equipment, Hospital-type beds, walkers, crutches and wheelchairs. Durable Medical Equipment is limited to the rental (but not to exceed the total cost of purchase) or, at the option of the Plan, the purchase of Durable Medical Equipment prescribed by a Member's attending Physician for therapeutic use. The rental/purchase includes the necessary fittings, adjustments, and delivery/installation of the Durable Medical Equipment. Coverage is also provided for necessary repairs to keep such equipment serviceable. Replacement coverage for previously purchased Durable Medical Equipment may only be considered when the equipment to be replaced can no longer be made serviceable. Prior Plan Approval is required for Durable Medical Equipment costing more than \$750 and all rentals.

11. HEARING AIDS

Coverage will be provided for the full cost of one (1) hearing aid per hearing-impaired ear up to one thousand four hundred dollars (\$1,400) every thirty-six (36) months for hearing aids for insured individuals under eighteen (18) years of age and all related services which shall be prescribed by an audiologist licensed under KRS Chapter 3334A and dispensed by an audiologist or hearing instrument specialist licensed under KRS Chapter 334. The insured may choose a higher priced hearing aid and may pay the difference in cost above the one thousand four hundred dollar (\$1,400) limit as provided in this section without any financial or contractual penalty to the insured or to the provider of the hearing aid.

12. HOME HEALTH CARE

Home Health Care Services as necessary to avoid or reduce hospitalization of a Member. Services must receive Prior Plan Approval and may include the provision of intermittent Skilled Nursing Care; intermittent physical therapy, and speech therapy; part-time or intermittent home health clinical services under the supervision of a registered nurse; medical supplies, laboratory services and intravenous drug therapy administered during a home health visit. These therapies, when received from a Home Health Agency, do not count towards a Member's Plan Year benefit maximum for Therapy Services. A visit of four (4) hours or less by a home health service is considered one Home Health Care visit.

13. HOSPICE CARE SERVICES

Hospice services are covered when a Member has been certified by a Physician to be terminally ill, with a life expectancy of six (6) months or less and elects Hospice coverage in lieu of continued attempts at cure. Hospice includes services, supplies and care to help provide comfort and relief from pain. All services are subject to Prior Plan Approval. Covered Services may include: Physician services, nursing care, medical appliances and supplies, drugs for an Outpatient for symptom management and pain relief, short term care for Inpatients including Respite Care, home health aides and homemaker services, physical therapy, occupational therapy and speech/language pathology services, and counseling, including dietary counseling. Respite care for inpatients is limited to five (5) days per stay. Inpatient Hospice is only covered at UK Albert B. Chandler Hospital or UK Samaritan Hospital.

14. HUMAN ORGAN AND TISSUE TRANSPLANTS

Benefits for human organ or tissue transplants are limited to kidney, cornea, certain bone marrow, heart, liver, lung, heart/lung, and pancreas transplants. The Plan does not provide benefits for procedures that are not Medically Necessary or Experimental or Investigational.

To be eligible to receive benefits, the Member must use a facility and/or provider approved by the Plan which is (are) qualified to perform the above transplant procedures and comply with the Prior Plan Approval process. No benefits will be paid for charges for the transplant if the procedure was not authorized prior to the pre-testing, evaluation and donor research.

Benefits for liver transplants are provided for Primary Biliary Cirrhosis, Primary Sclerosing Cholangitis, Postnecrotic Cirrhosis Hepatitis B Surface Antigen Negative, Alcoholic Cirrhosis (only if 6 months abstinence from alcohol is documented), Alpha-1 Antitrypsin Deficiency Disease, Wilson's Disease, Primary Hemochromatosis Biliary Atresia, Inborn errors of metabolism that are life threatening (tyrosinemia, oxalosis, glycogen storage diseases, etc.), protophyria, Byler's Disease, non-alcoholic steatohepatitis, Diseases caused by cirrhosis, toxic reactions; Budd-Chiari syndrome, Alagill's syndrome, amyloidosis, polycystic disease and familial amyloid polyneuropathy.

Benefits for liver transplants will also be provided for primary hepatic carcinoma. For this condition, liver transplant is covered only if the cancer does not extend beyond the margins of the liver. Benefits are not provided for liver transplant for cholangiocarcinoma or metastatic carcinomas. For the purposes of this section, metastatic refers to cancer cells transmitted to the liver from an original site elsewhere in the body. Benefits are provided for Medically Necessary adult-to-adult right lobe living donor liver transplant.

Benefits are not provided for adult-to-adult left lobe living donor liver transplant.

Benefits are provided for heart transplants that are Medically Necessary and not Experimental or Investigational.

Benefits for bone marrow (allogeneic, autologous and peripheral blood stem cells and cord blood) transplants are provided for the following conditions provided they are Medically Necessary:

Covered Diseases

Acute Lymphocytic Leukemia	Covered
Acute Myelogenous Leukemia	Covered
Chronic Lymphocytic Leukemia	Covered
Chronic Myelogenous Leukemia	Covered
Primitive Neuroectodermal Tumors	Covered
Pediatric Neuroblastoma	Covered
Recurrent Ewing's Sarcoma	Covered

14. HUMAN ORGAN AND TISSUE TRANSPLANTS (Cont.)

Germ Cell Tumors	Covered
Multiple Myeloma	Covered
Hodgkin's Lymphoma	Covered
Non-Hodgkin's Lymphoma	Covered
Myelodysplastic Diseases	Covered
Aplastic Anemia	Covered
Wiskott-Aldrich Syndrome	Covered
Severe Combined Immunodeficiency Disorder	Covered
Albert-Schoenberg Syndrome	Covered
Homozygous Beta-Thalassemia	Covered

Non-covered Diseases

Small Cell Lymphocytic Leukemia	Not Covered
Epithelial Ovarian Cancer	Not Covered
Malignant Astrocytomas and Glioma	Not Covered
Ependymoma	Not Covered
Any Tandem Procedures	Not Covered

Benefits are provided for bone marrow transplant for breast cancer only if required by law.

Unless specifically named in this Certificate, benefits are not provided for bone marrow transplants (allogeneic, autologous or peripheral blood stem cells) for treatment of myeloproliferative diseases other than those explicitly named above, cancers or diseases of the brain, bone, large bowel, small bowel, esophagus, kidney, liver, lungs, pharynx, prostate, skin, connective tissue and uterus.

As used in this document, the term "bone marrow transplant" means human blood precursor cells which are administered to a patient following ablative or myelosuppressive therapy. Such cells may be derived from bone marrow, circulating blood obtained from the patient in an autologous transplant or from a matched related or unrelated donor. If chemotherapy is an integral part of the treatment involving bone marrow transplantation, the term "bone marrow transplant" includes the harvesting, the transplantation and the chemotherapy components.

Benefits are provided for lung transplants that are Medically Necessary and not Experimental or Investigational.

Benefits are provided for heart/lung transplants that are Medically Necessary and not Experimental or Investigational.

Lobar lung replacement is covered for irreversible, end-stage pulmonary disease provided the excised lobe is sized appropriately for the recipient's thoracic dimensions.

Benefits for pancreas transplants will be provided only if performed simultaneously with or following a kidney transplant or for life threatening severe hypoglycemic unawareness.

A. Benefit Eligibility

When Physician's services are required for kidney, cornea or bone marrow transplants from a living donor to a transplant recipient requiring surgical removal of a donated part, the following will determine the benefits to be provided, but only when the physician customarily bills the recipient for such services.

1. When the transplant recipient and donor are both Members under this Plan, benefits will be provided for both under each individual's available coverage.

14. HUMAN ORGAN AND TISSUE TRANSPLANTS (Cont.)

A. Benefit Eligibility (continued)

2. When only the transplant recipient is eligible under this Plan, benefits will be provided for both to the extent that benefits to the donor are not provided under any other coverage. In such instances, donor utilization of benefits will be charged against the recipient's coverage.
3. When the transplant recipient is not eligible under this Plan, and the donor is, the donor will receive his or her Plan benefits for surgical and medical care necessary to the extent such benefits are not provided by any coverage available to the recipient for the organ or tissue transplant procedure.

Benefits will not be provided to any non-eligible transplant recipient.

Non-covered Diseases

Chronic Lymphocytic Leukemia	Not Covered
Small Cell Lymphocytic Leukemia	Not Covered
Epithelial Ovarian Cancer	Not Covered
Malignant Astrocytomas and Glioma	Not Covered
Ependymoma	Not Covered
Any Tandem Procedures	Not Covered

Benefits are provided for bone marrow transplant for breast cancer only if required by law.

Unless specifically named in this Certificate, benefits are not provided for bone marrow transplants (allogeneic, autologous or peripheral blood stem cells) for treatment of myeloproliferative diseases other than those explicitly named above, cancers or diseases of the brain, bone, large bowel, small bowel, esophagus, kidney, liver, lungs, pharynx, prostate, skin, connective tissue and uterus.

As used in this document, the term "bone marrow transplant" means human blood precursor cells which are administered to a patient following ablative or myelosuppressive therapy. Such cells may be derived from bone marrow, circulating blood obtained from the patient in an autologous transplant or from a matched related or unrelated donor. If chemotherapy is an integral part of the treatment involving bone marrow transplantation, the term "bone marrow transplant" includes the harvesting, the transplantation and the chemotherapy components.

Benefits are provided for lung transplants that are Medically Necessary and not Experimental or Investigational.

Benefits are provided for heart/lung transplants that are Medically Necessary and not Experimental or Investigational.

Lobar lung replacement is covered for irreversible, end-stage pulmonary disease provided the excised lobe is sized appropriately for the recipient's thoracic dimensions.

Benefits for pancreas transplants will be provided only if performed simultaneously with or following a kidney transplant or for life threatening severe hypoglycemic unawareness.

A. Benefit Eligibility

When Physician's services are required for kidney, cornea or bone marrow transplants from a living donor to a transplant recipient requiring surgical removal of a donated part, the following will determine the benefits to be provided, but only when the physician customarily bills the recipient for such services.

1. When the transplant recipient and donor are both Members under this Plan, benefits will be provided for both under each individual's available coverage.

14. HUMAN ORGAN AND TISSUE TRANSPLANTS (Cont.)

A. Benefit Eligibility (continued)

2. When only the transplant recipient is eligible under this Plan, benefits will be provided for both to the extent that benefits to the donor are not provided under any other coverage. In such instances, donor utilization of benefits will be charged against the recipient's coverage.
3. When the transplant recipient is not eligible under this Plan, and the donor is, the donor will receive his or her Plan benefits for surgical and medical care necessary to the extent such benefits are not provided by any coverage available to the recipient for the organ or tissue transplant procedure.

Benefits will not be provided to any noneligible transplant recipient.

B. Eligible Expenses

1. Eligible Expenses include charges incurred by the recipient for Covered Services that are directly related to or result from the completion of a covered transplant procedure, including all pre-operative and post-operative services.
2. Eligible Expenses also include charges which are directly related to the surgical, storage, and transportation costs incurred in the donation of an organ for a covered transplant procedure. Eligible Expenses exclude any expenses incurred by a living donor for transportation, meals, or lodging.
3. In order to pre-authorize the transplant procedure itself, the Plan must be given the opportunity to review the clinical results of the evaluation. Approval will be based on written criteria and procedures established or adopted by the Plan.
4. Reasonable and necessary transportation if the transplant is to be performed more than 75 miles from the Member's home. Meals and lodging expenses are covered to and from the site of the Covered Transplant procedure and while at the site of the Covered Transplant Procedure for the Member and a companion within reasonable limits determined by the Plan. If the Member is a minor, expenses for transportation, meals and lodging will be covered for two companions. Transportation reimbursement will not exceed \$10,000 per transplant.

C. Non-Eligible Expenses

1. No benefits will be paid unless your coverage is in effect on the date the covered procedure is performed.
2. In addition to the Exclusions applicable under the Plan, benefits will not be provided for covered expenses:
 - a. related to the transplant of any non-human organ or tissue, or
 - b. which are repaid under any private or public research fund.
3. Denied charges for a covered procedure or non-covered expenses in connection with a covered procedure are not eligible for payment under any other part of this Plan.
4. Any human organ or tissue transplant not specifically listed in this Certificate.

Questions regarding adult and pediatric Organ Transplants should be directed to the UKHMO Medical Management Department which can be reached by calling (877) 855-9700. Physicians and Registered Nurses experienced in the management of Organ Transplant benefits assist Members through coordination of the processes described in this Section.

15. IMMUNIZATIONS AND INJECTIONS

- A. Pediatric and adult immunizations, in accordance with recommendations of the Advisory Council on Immunization Practices of the Centers for Disease Control and Prevention as medically necessary, except as otherwise excluded in this Certificate. Benefits are not provided for immunizations performed by the Preventive Medicine Clinic at Kentucky Clinic South.
- B. Therapeutic injections;
- C. Factor 8 and 9 for blood clotting enhancements in relation to hemophilia, and immune globulin when Medically Necessary for the Member's condition. Prior Plan Approval is required

16. MATERNITY CARE

Coverage is provided for treatment of an Inpatient and Outpatient for prenatal visits, delivery, and postpartum care provided to the Subscriber, Covered Spouse, or Covered Dependent. Coverage is provided for newborn services provided to the child(ren) of the Subscriber or Covered Spouse when the infant is an enrolled eligible Dependent of the Subscriber as defined in the Enrollment and Effective Date section of the General Provisions (see page 45). Coverage includes, but is not limited to, the necessary care and treatment of covered congenital disorders and birth abnormalities, and inherited metabolic diseases, including complications thereof. Coverage also includes in-hospital hearing screening of a newborn. Coverage for newborns when not enrolled as a dependent is limited to inpatient care with coverage up to 31 days.

The Plan will provide coverage:

- A. As required by Federal Law, Inpatient care for a mother and her newborn child(ren) for a minimum of forty-eight (48) hours after vaginal delivery and a minimum of ninety-six (96) hours after delivery by Cesarean section; or
- B. For a shorter length of stay, with the consent of the mother, if the treating Physician determines that the mother and the newborn meet medical stability criteria and the Plan authorizes an initial postpartum home health care visit which includes the collection of an adequate sample for hereditary and metabolic newborn screening if requested.

17. MEDICAL CASE MANAGEMENT

The Plan may extend coverage of Covered Services or offer benefits for non-covered services under a medical case management program, if to do so would be a medically appropriate, cost effective alternative. The Plan and the Provider must be in agreement on the treatment plan and the Member fully informed of options and consequences of the decision. The Provider is required to furnish a Plan of Treatment for the Member, which must be approved by the Plan as part of the determination of the Member's eligibility for medical case management. The Provider must also keep the Plan informed of the Member's progress and prognosis on an ongoing basis.

18. MENTAL HEALTH/CHEMICAL DEPENDENCE SERVICES

A. MENTAL HEALTH SERVICES

Covered Services for the diagnosis and treatment of Mental Health Conditions when rendered by a UK Participating Hospital, Physician, or other applicable Provider, to the extent specified in the Schedule of Benefits, subject to periodic review, as determined by the Plan.

1. INPATIENT SERVICES

Inpatient Hospital or Psychiatric Facility services for the treatment of Mental Health Conditions in an acute crisis. Benefits are provided for non-excluded therapy services. **Benefits are not provided for room and board charges in a residential treatment facility.**

Benefits are also provided for:

- Individual Psychotherapy Treatment;
- Group Psychotherapy Treatment;
- Psychological Testing; and
- Convulsive Therapy Treatment.

Electroshock treatment or convulsive drug therapy, including anesthesia when administered concurrently with the treatment by the same Physician or other professional Provider.

2. DAY TREATMENT/INTENSIVE OUTPATIENT PROGRAM

The treatment of a Mental Health Condition in a day treatment/intensive Outpatient program primarily used to assist Members during an acute psychiatric crisis. Benefits for this type of program are available on the same basis as benefits for inpatients. Partial days/Intensive Outpatient days may be substituted for Inpatient days on a 1:1 ratio.

3. OUTPATIENT SERVICES

The treatment of a Mental Health Condition when rendered by a Hospital, Physician, or other applicable Provider for services to an Outpatient, including individual and group psychotherapy treatment and psychological testing.

4. AUTISM

Benefits are provided for non-excluded therapy. Respite and rehabilitative care for a Member age 2 through 21 for the treatment of Autism. The maximum dollar limit for this benefit shall not apply to other health or Mental Health Conditions of the Member which are not related to the treatment of Autism

B. CHEMICAL DEPENDENCE

Individual and group counseling and psychotherapy, psychological testing, and family counseling for the treatment of short-term Chemical Dependence, when rendered to a Member by a Hospital, Chemical Dependence Treatment Facility, Physician, or other applicable Provider. Benefits are subject to Delivery System Rules and periodic review as established by the Plan.

1. INPATIENT SERVICES

Services rendered to an Inpatient by a Hospital or short-term Chemical Dependence Treatment Facility for the treatment of Chemical Dependence. Services to an Inpatient will be authorized only when deemed the least restrictive mode of treatment. Benefits are provided for non-excluded therapy services. **Benefits are not provided for room and board charges in a residential treatment facility.**

Benefits are also provided for:

- Individual Treatment;
- Group Treatment; and
- Testing.

2. DAY TREATMENT/INTENSIVE OUTPATIENT PROGRAMS

The treatment of Chemical Dependence in a day treatment or intensive Outpatient program primarily used to assist patients during an acute crisis. Benefits for this type of program are available on the same basis as benefits to Inpatients. Partial days/Intensive Outpatient days may be substituted for Inpatient days on a 1:1 ratio.

3. OUTPATIENT SERVICES

The treatment of Chemical Dependence when rendered by a Hospital, Chemical Dependence Treatment Facility, Physician, or other applicable Provider for services to an Outpatient, including individual treatment, group treatment and testing.

19. NURSING FACILITY SERVICES

Room and board (including special diets) in semi-private accommodations in an approved Nursing Facility for skilled nursing or rehabilitation.

20. ORAL SURGERY

Charges made by a qualified practitioner for services in performing certain oral surgical operations due to bodily injury or sickness are covered as follows:

1. Excision of partially or completely unerupted impacted teeth
2. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological examination
3. Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth
4. Reduction of fractures and dislocations of the jaw
5. External incision and drainage of cellulites

21. PRESCRIPTION DRUGS/MEDICAL SUPPLIES

Medical supplies, allergy serum and drugs used in the direct administration of a Covered Service by a Provider are covered.

22. PROSTHETIC APPLIANCES/ORTHOTIC DEVICES

A. PROSTHETIC APPLIANCES

Coverage for the purchase, fitting and necessary adjustments, repair or replacement of prosthetic appliances which replace all or part of an absent body part (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning body part. Prior Plan Approval requirements apply.

B. ORTHOTIC DEVICES

Coverage for the purchase, fitting and necessary adjustments of braces and splints which are professionally fitted, Medically Necessary for the treatment of the condition and required to allow activities of daily living. Professionally fitted shoe inserts, Medically Necessary for the treatment of complications of diabetes. Prior Plan Approval requirements apply.

23. REPRODUCTIVE HEALTH CARE AND FAMILY PLANNING SERVICES

Benefits are provided for history, physical examinations, laboratory tests, and medical supervision related to family planning when rendered by a UK Participating Provider in accordance with locally accepted medical practice.

Benefits are provided for Medically Necessary genetic testing and counseling when rendered by a Participating Physician in accordance with locally accepted medical practice.

Benefits are provided for medically necessary pregnancy terminations to preserve the life of the mother upon whom the abortion is performed when provided by a UK Chandler Hospital physician and authorized in advance by the Plan.

24. SECOND OPINION

The Plan can require a Member to obtain a second opinion evaluation from a UK Provider for a proposed medical treatment or surgical procedure. Medical treatment or surgical procedure is defined as covered procedures that may be safely deferred and do not involve an Emergency Medical Condition.

If the Plan requires a second opinion evaluation, the Plan may also specify from whom the second opinion must be obtained. The Physician must be qualified to provide treatment for the Member's condition.

If the Plan requires a Member to obtain a second opinion prior to the recommended procedure or treatment, the Plan will cover the second opinion in full. The Covered Services will include the consulting Physician's second opinion consultation and any directly related Diagnostic Services required by the Plan to be performed to confirm the need for the procedure or treatment as first recommended.

When a Member obtains a second opinion evaluation not required by the Plan, such evaluation must be obtained within the procedures specified in the Plan's Delivery System Rules for coverage to apply.

25. TELEHEALTH CONSULTATION SERVICES

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

- A. compressed digital interactive video, audio, or data transmission; and
- B. clinical data transmission via computer imaging for teleradiology or telepathology.

26. TEMPOROMANDIBULAR JOINT DISORDER

Covered Services incurred for surgical treatment of temporomandibular joint (TMJ) disorder provided the charges are for services included in a treatment plan that receives Prior Plan Approval.

Covered Services for nonsurgical diagnosis and treatment of TMJ dysfunction or disorder is limited to: (a) diagnostic examination; (b) diagnostic x-rays; (c) injection of muscle relaxants; (d) therapeutic drug injections; (e) physical therapy; (f) diathermy therapy; (g) ultrasound therapy; and (h) arthrocentesis and aspiration.

Benefits are not provided for charges for anything not listed above, including but not limited to: (a) any appliance or the adjustment of any appliance involving orthodontics; (b) any electronic diagnostic modalities; (c) occlusal analysis; (d) muscle testing; (e) splint therapy, and (f) biteguards.

27. THERAPY AND CHIROPRACTIC SERVICES

The treatment of an acute condition, by manual or physical means, including therapy and spinal manipulation. The number of covered therapy visits specified in the Schedule of Benefits applies cumulatively to physical therapy, occupational therapy, chiropractic manipulative therapy/osteopathic manipulative therapy, acupuncture and pool therapy/exercise hydrotherapy and speech therapy. Modalities are considered part of the therapy service and are not reimbursed separately.

A. PHYSICAL THERAPY

The treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, biomechanical and neurophysiological principles, and devices to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of a body part.

B. OCCUPATIONAL THERAPY

The treatment program of prescribed activities, emphasizing coordination and mastery, designed to assist a person to regain independence, particularly in the normal activities of daily living.

C. CHIROPRACTIC MANIPULATIVE THERAPY

This treatment is a form of manual treatment to influence joint and neurophysiologic function. This treatment may be accomplished by a variety of techniques. Benefits are provided only for the treatment of an acute condition. Benefits are provided only for spinal manipulation.

D. OSTEOPATHIC MANIPULATIVE THERAPY

This treatment is a form of manual treatment applied by a specially trained Physician to eliminate or alleviate somatic dysfunction and related disorders.

E. SPEECH THERAPY

The treatment rendered to restore acute speech loss due to illness or Accidental Injury to the mechanisms of speech.

F. CARDIAC REHABILITATION THERAPY

Cardiac rehabilitation (rehab) is a medically supervised program that helps improve the health and well-being of people who have heart problems. Rehab programs include exercise training, education on heart healthy living, and counseling to reduce stress and help you return to an active life. Inpatient admission for the sole purpose of cardiac rehabilitation is not a covered benefit.

Outpatient physical, occupational, cardiac rehabilitation and speech therapy services received from a Home Health Agency are considered Home Health Care services. Therapy provided through home health does not count towards the Member's Plan Year Therapy Services maximum benefit limit but does count towards their home health limits.

G. PULMONARY REHABILITATIVE THERAPY

Pulmonary Rehabilitation is a program of education and exercise classes that teaches you about your lungs, how to exercise and do activities with less shortness of breath, and how to "live" better with your lung condition. Benefits for Pulmonary Rehabilitative Therapy must be rendered as an Outpatient.

I. ACUPUNCTURE THERAPY

A Chinese medical practice that involves the insertion of hair-fine needles into nonanatomic energy channels, called meridians. **This will only be covered when services are performed by a specially trained medical doctor only (M.D.).**

H. POOL THERAPY/EXERCISE HYDROTHERAPY

A physical therapy modality that involves the therapeutic use of water to treat a number of conditions under the supervision of a medically trained professional. Hydrotherapy may also be referred to as aquatic therapy or pool exercise therapy. Hydrotherapy must be administered as direct, one-on-one patient contact. This does not include group programs. Services must be performed as UK Samaritan Physical Therapy Department.

27. THERAPY AND CHIROPRACTIC SERVICES (cont)

J. HOME HEALTH

Intermittent skilled nursing and health related services to Members in their home under a plan prescribed by a physician

28. TOBACCO CESSATION COUNSELING

Coverage for Tobacco Cessation Counseling will now be covered by UK-HMO. To have this service covered, services must be performed by the UK Tobacco Treatment Specialist, Audrey Darville, ARNP, CTTS. These sessions are available through the Internal Medicine Clinic. To schedule an appointment please call 323-0303. For questions, call 323-4222 or e-mail audrey.darville@uky.edu.

The University is providing Nicotine Replacement products (patches and gum) at no charge to employees and their spouses or sponsored dependents who are enrolled in one of the designated UK Tobacco Dependence treatment programs.

29. URGENT CARE SERVICES

Benefits are provided for Urgent Care when care: (1) is required to prevent serious deterioration in the Member's health, (2) is not an Emergency Medical Condition, but requires prompt medical attention, (3) includes care for the treatment of significant injuries as a result of accidents, the relief or elimination of severe pain, or the moderation of an acute illness, and (4) is obtained in accordance with the Plan's Delivery System Rules (see page 6)

EXCLUSIONS

The following Section indicates items which are excluded from benefit consideration, and are not considered Covered Services. Services and treatment for complications related to Non-Covered Services are excluded from benefit coverage. This information is provided as an aid to identify certain common items which may be misconstrued as Covered Services, but is in no way a limitation upon, or a complete listing of, items considered not to be Covered Services. The titles of each section are to facilitate location of the exclusions and should not be interpreted to limit the terms of the exclusions. These exclusions apply regardless of Medical Necessity.

Abortion - Services, supplies and other care provided for elective abortions, as defined by Kentucky statute, except as medically necessary to preserve the life of the mother.

Anesthesia by Hypnosis - Services, supplies, or other care for anesthesia by hypnosis, or charges for anesthesia for services not covered by this Plan.

Alcohol/Chemical Dependence/Substance Abuse - Services, supplies, or other care associated with the treatment of Alcohol/Chemical Dependence/Substance Abuse in the event the Member fails to comply with the plan of treatment (such as detoxification, rehabilitation or care as an Outpatient) for which the services, supplies, or other care was rendered or a claim was submitted or if the Member is discharged against the medical advice of the attending Physician.

Behavioral Training and Modifications - Services, supplies, or other care, which are provided for conditions related to conduct disorders (except attention deficit hyperactivity disorders), pervasive developmental disorders (except Autism), behavioral disorders, learning disabilities and disorders, or mental retardation. Services, supplies or other care for non-chemical addictions such as gambling, sex, spending, shopping and working addictions, codependency or caffeine addiction. Milieu therapy, marriage counseling, inpatient admissions, residential or institutional care that is for the primary purpose of controlling or changing the Member's physical, emotional, or relational environment. Biofeedback, neuromuscular reeducation, hypnotherapy, sleep therapy, vocational rehabilitation, sensory integration, educational therapy and recreational therapy, except for such adjunct services as part of the Inpatient stay and required by the Joint Commission on Accreditation of Healthcare Organizations or the Commission on Accreditation of Rehabilitation Facilities.

Blood and Related Products - Charges for the cost of whole blood, blood cellular components or whole plasma, storage of blood and blood products, including cord blood

Chelation Therapy - Chelation therapy except in the treatment of lead or other heavy metal poisoning.

Civil Disturbance/Crime - Services, supplies, or other care provided in the treatment of injuries sustained or illnesses resulting from participation in a riot or civil disturbance or while committing or attempting to commit an assault or felony. Services, supplies or other care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs.

Coordination of Benefits - Services, supplies, or other care to the extent that benefits or reimbursement are available from or provided by any other coverage (except Medicaid) including Medicare, except that the Plan will coordinate the payment of benefits under this Plan with such other coverage or as permitted by Kentucky law. All UK-HMO Plan Delivery System Rules must be followed to have services covered by the plan.

Cosmetic Services - Services, supplies, or other care for cosmetic surgery, and/or complications arising from cosmetic services. Cosmetic services mean surgical procedures performed to improve a Member's appearance or to correct a deformity without restoring physical bodily function. The presence of a psychological condition does not make a cosmetic service Medically Necessary and will not entitle a Member to coverage for cosmetic services. Examples of exclusions include, but are not limited to, removal of birthmarks including port wine stains and other vascular birthmarks; moles; warts (unless under the age of 18); tattoos; scars; wrinkles or excess skin; skin tags; panniculectomy; gynecomastia; plastic surgery; silicone injections or implants; electrolysis; wigs including those used as cranial prostheses; treatment of male pattern baldness; revision of previous elective procedures; keloids; pharmaceutical regimes; nutritional procedures or treatments; rhinoplasty; epikeratophakia surgery; skin abrasions which are performed as a treatment for acne; helmet or other prosthetic treatment for positional plagiocephaly. Benefits are not provided for cosmetic surgery except when referred by your Primary Care Physician and approved by the Plan as Medically Necessary for prompt repair of an Accidental injury, or for correction of a congenital anomaly of a child enrolled on the UK Medical Benefits Plan since birth.

Custodial Care - Services, supplies, or other care rendered by or in rest homes, health resorts, homes for the aged or places primarily for domiciliary or Custodial Care, self-help training or other form of non-medical self-care.

Dental Services - Dental services or appliances for the treatment of the teeth, gums, jaws, or alveolar processes, including but not limited to implants and related procedures, and orthodontic procedures, unless specifically provided under this plan. Expenses incurred for which you are entitled to receive benefits under your previous dental or medical plan. No benefits are payable for any dental examinations; dental osteotomies; or splint therapy. Oral appliances or splint therapy for sleep apnea is not covered. Biteguards are not covered.

Devices - Devices of any kind, including those requiring a prescription, including but not limited to: therapeutic devices, health appliances, hypodermic needles, hearing aids (unless under age 18), or similar items.

Disposable Supplies - Disposable supplies to an Outpatient including but not limited to Ace ® bandages, support hosiery, pressure garments, elastic stockings, and band aids.

Durable Medical Equipment – Expenses for services that are primarily and customarily used for environmental control or enhancement (whether or not prescribed by a qualified practitioner) and certain medical devices including but not limited to: Motorized transportation equipment (e.g. scooters), purchase or rental of escalators, elevators or stair gliders, ramps, or modifications or additions to living/working quarters or transportation vehicles. Spas, saunas or swimming pools; whirlpool baths, hot tubs, exercise and massage equipment. Emergency alert equipment, professional medical equipment such as blood pressure kits or pulse oximetry machines. Modifications to a home or place of business, such as ramps or handrails. Air purifiers, humidifiers, dehumidifiers, air conditioners or heat appliances. Bathtub chairs, seat lift chairs or waterbeds. Bedding including, but not limited to, mattresses, mattress pads, mattress covers, pillows. Adjustments made to vehicles. Computers. Penile implants. Hearing aids, except for children under age 18 covered at \$1,400 per hearing aid every 36 months. Supplies or attachments for any of these items. Any Durable Medical Equipment having convenience or luxury features which are not Medically Necessary, except that benefits for the cost of standard equipment or device used in the treatment of disease, illness, or injury will be provided toward the cost of any deluxe equipment. Replacement or repair of Durable Medical Equipment damaged through neglect, abuse or misuse. Maintenance costs for Member-owned Durable Medical Equipment.

Education - Services, supplies, or other care for educational or training purposes used in connection with disabilities of language, hearing, or vision; disorders or disabilities of speech, including developmental dysfluencies. This exclusion applies to Attention Deficit Disorder.

Effective Dates - Except as otherwise required by law, benefits are not provided for services, supplies, or other care rendered prior to the Group Effective Date of this Plan, or after the termination date of this Plan, or prior to the Member's Effective Date or after the Member's termination date.

Emergency Room - Benefits are not provided for the use of an emergency room except for treatment of Emergency Medical Conditions, screening and stabilization.

Experimental/Investigational Services - Services, supplies, or other care which are Experimental or Investigational in nature or related complications. Please review the definition of Experimental or Investigational in the Definitions section.

Eye Related Services - Eyeglasses (including contact lenses) and examinations for them, whether or not prescribed (except for implanted cataract lenses following surgery for cataracts or similar medical condition). Treatment for the correction of refractive error, including but not limited to radial keratotomy or keratomileusis.

Family Member Provider - Services, supplies, or other care rendered by a Provider who is a member of the Member's immediate family. Immediate family includes you, your spouse, child, brother, sister, parent or in-law of you or your spouse.

Foot Related Services - Services and supplies for routine foot care or other care, unless Medically Necessary for the treatment of complications of diabetes, circulation or immuno-compromised status. Such excluded services and supplies include, but are not limited to, the following: treatment or supplies for superficial lesions of the feet such as corns, hyperkeratosis, calluses, plantar warts, and fungal infections; treatment of nails of the feet (except surgery for ingrown toenails); shoe inserts and foot orthotics; shoes, except as a Medically Necessary attachment to a prosthesis; treatment or supplies for flat feet; fallen arches, weak feet, or similar conditions; treatment supplies or surgery for bunions, tarsalgia, metatarsalgia (except capsular or osteotomy). Extracorporeal shockwave lithotripsy (ESWL) except for the treatment of urinary tract stones. Surgery performed by Podiatrists without UK Hospital privileges. These patients should be referred to UK Podiatrist or UK Orthopedics.

Governmental Health Plans - Services, supplies or other care to the extent that benefits are available under any governmental health plan (including military service-related expenses in Veterans Administration Hospitals, but excluding Medicaid), except that the Plan will coordinate the payment of benefits under the Plan, in accordance with and subject to the Plan's Delivery System Rules, with such other governmental health plans as permissible under existing laws and regulations.

Hearing Related Services - Routine hearing tests or screenings (except screening of a newborn in the Hospital and basic hearing examinations up to and including an audiometric examination through the age of 17). Hearing aids, except for children under the age of 18 covered at a maximum of \$1,400 per hearing aid every 36 months. Replacement or repair of hearing aids except as stated above.

Heart Related Services - Services, supplies, or other care provided to an Inpatient solely for cardiac rehabilitation. Services, supplies, implantation, removal and complications, or other care provided for non-human, artificial or mechanical hearts or ventricular and/or atrial assist devices used as a heart replacement (with the exception of temporary heart assist devices approved by the FDA, as a bridge to a Plan-approved heart transplantation) and supportive services or devices in connection with such care.

Home Health Care - Benefits are not provided for food, housing, home delivered meals, and homemaker services (such as housekeeping, laundry, shopping and errands). Teaching household routine to members of family; supervision of children and other similar functions. Benefits are not provided for home health care education beyond the normal and reasonable period for learning. Supportive environmental materials; such materials include handrails, ramps, telephones, air conditioners and similar items. Services or supplies provided by the family of the Member or volunteer ambulance associations. Visiting teachers, friendly visitors, vocational guidance and other counselors. Services related to diversional and social activities. Services for which there is no cost to the Member. Services not authorized, not included in the Physician's prescribed treatment plan, services provided by an immediate family member, and Custodial Care.

Hospice - Services, supplies or other care not otherwise covered by Medicare's Hospice benefit. Inpatient Hospice services must be performed at UK Albert B. Chandler Medical Center or Samaritan Hospital.

Infertility - No coverage is provided for infertility services. No coverage is provided for reversal or any attempted reversal of a previously performed sterilization.

Inpatient Diagnostic/Therapy Non-emergency diagnostic admissions for inpatients or admissions primarily for therapy services, unless pre-authorized by the plan.

Laetrile - Services, supplies, or other care directly provided in conjunction with laetrile, including the cost of the laetrile.

Lipectomy - Benefits are not provided for services and supplies related to lipectomy or suction-assisted lipectomy or diastasis recti repair, including instances when diastasis recti is associated with an umbilical or ventral hernia.

Maternity - Care of the newborn of a dependent other than normal inpatient newborn nursery charges.

Medical Records - Services, supplies, or other care for which the Plan has been unable to obtain sufficient information from a Provider or the Member in order to determine Medical Necessity or to process any claim. Charges for copying or obtaining Medical Records needed by the Plan for utilization, claims or quality review.

Mental Health Services - Services for Mental Health Conditions, when performed by other than a Physician or Provider licensed or certified by the Commonwealth of Kentucky or corresponding license or certification if provided by Physicians or other Providers outside the Commonwealth. Services for Mental Health Conditions when provided to a Member for purposes of medical, educational, or occupational training. Court ordered exams or treatment that are not Medically Necessary as determined by the Plan or that exceed benefits specified in the Schedule of Benefits, if any. Psychological testing beyond that necessary to establish the diagnosis or beyond that approved by the Plan. **Treatment at a residential medical treatment facility.** Residential or institutional care that is for the primary purpose of controlling or changing the Member's physical, emotional or relational environment.

Multiple Organ Transplants - Services or supplies for any multiple human organ transplant to the extent that the transplant also involves the transplantation of the stomach, and/or pancreas, and/or small intestine, and/or colon.

No Demonstrated Improvement in Outcome or Cost-Benefit - Services, treatments, devices or drugs for a condition or illness which, as determined by the Plan according to its established technology assessment policies and procedures, are not shown by the published peer-reviewed medical literature to result in health outcomes that are better than health outcomes for other available and accepted services, treatments, devices or drugs for such condition or illness. Services, treatments, devices or drugs for a condition or illness for which, as determined by the Plan according to its established technology assessment policies and procedures, the cost-benefit is not shown by the published peer-reviewed medical literature to be similar to currently available and accepted services, treatments, devices or drugs for such condition or illness.

Non-Covered Services - Services, supplies or other care not specifically provided for in this Certificate or that are excluded by this Certificate. Services exceeding any maximum benefit or benefit limit established by this Certificate. Complications of a Non-Covered Service.

Non-Medical Services - Services, supplies or other care for personal hygiene, environmental control or convenience items (including, but not limited to, air conditioners, humidifiers, dehumidifiers, or physical fitness equipment), or personal comfort and convenience items (such as daily television rental, telephone services, cots or visitors' meals). Charges for (1) telephone consultations, (2) failure to keep a scheduled visit (3) services or treatments not begun or not completed because of patient's decision against medical advice, (4) completion of a claim form, or (5) providing requested information to the Plan. Services or supplies provided for self-help training or other form of non-medical self-care. Purchase or rental of

Non-Medical Services (cont.) - supplies of common household use such as exercise cycles, air purifiers, central or unit air conditioners, water purifiers, pillows or mattresses or waterbeds, treadmill or special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program, including pulmonary rehabilitation. Services or supplies at a health spa or similar facility. Shoes, except as a Medically Necessary attachment to a prosthesis.

Non-Participating Providers - Services, supplies or other care delivered by Non-Participating Providers in a manner not consistent with the Plan's Delivery System Rules.

Not Medically Necessary - Services, supplies or days of care that are not Medically Necessary for the diagnosis or treatment of an injury, illness, or symptomatic complaint. The fact that a Physician or other Provider may prescribe, order, recommend or approve a service or supply does not of itself make it Medically Necessary or make the service a Covered Service. This applies even though the service or supply is not specifically listed as an exclusion. The Plan is the final authority for determining whether all services are Medically Necessary.

Nursing Facilities - Services, supplies or other care in a Nursing Facility not requiring daily planned medical and skilled professional nursing care and supervision for a disease, illness or injury.

Nutritional Services - Food, food supplements, minerals, vitamins, or drugs which could be purchased without a written prescription, or are not F.D.A. approved for treatment of a specified category of medical conditions or are considered to be Experimental or Investigational. Coverage for any modified food for the treatment of lactose intolerance, protein intolerance, food allergy, food sensitivity, or any other condition or disease are excluded except for those inherited metabolic diseases listed in the Prescription Benefit Section under Special Foods for Inborn Errors of Metabolism.

Obesity - Weight reduction programs, weight management programs, related nutritional supplies, strengthening programs and wellness programs. Treatment for obesity (including surgery for morbid obesity). Any surgery for the removal of excess fat or skin following weight loss due to the treatment of obesity, surgery, or pregnancy. Services at a health spa or similar facility. Services, supplies, or other care for gastric bubble/gastric balloon procedures. Additional examples of excluded services are stomach stapling, wiring of the jaw, liposuction, dietary supplements and jejunal bypasses.

Obligation to Pay Services - Services, supplies, or other care for which the Member has no legal obligation to pay in the absence of this or similar coverage, or for which no charge has been made.

Out-of-Network Services - Except for services for Emergency Medical Conditions and Urgent Care services, benefits are not provided for services from Non-Participating Providers except as permitted by the Plan Delivery System rules.

Outside United States - Non-emergency treatment provided outside the United States.

Physical Exams - Except as otherwise provided, services, supplies, or other care for routine or periodic physical examinations. Except if part of a covered preventive service visit, tests for screening purposes required by third parties, such as for employment, licensing, travel, school, insurance, marriage, adoption, participation in athletics. Services conducted for the part of medical research or examination required by a court.

Prosthetic Appliances, Orthotic Devices - Splints, braces, wraps or other temporary orthotics made with elastic, cloth, plastic, composite material, synthetics, metal, rubber, unless professionally fitted and necessary to perform all activities of daily living, whether purchased by the Member or supplied by a Provider. Any orthotic device which is the equivalent of a device that can be purchased over-the-counter. AirCasts™ and other pneumatic stabilization devices unless the device replaces the use of a cast for treatment of a condition requiring casting. Any Prosthetic Appliance or Orthotic Device having convenience or luxury features which are not Medically Necessary, except that benefits for the cost of standard equipment or device used in the treatment of disease, illness, or injury will be provided toward the cost of any deluxe appliance. Repair, maintenance and/or replacement of a Prosthetic Appliance or Orthotic Devices, , except as otherwise provided.

Sex Transformation/Sexual Dysfunction - Services, supplies, drugs or other care related to sex transformation, gender identity, sexual or erectile dysfunction or inadequacies.

Sleep Apnea Services -Purchase of positive pressure airway devices where, during the initial rental period, there is no documentation of use on at least 50% of nights and total average nightly use of at least 4 hours. Oral appliances or splint therapy for sleep apnea is not covered.

Students Away From Home - Routine services obtained by Non-Participating Providers in a manner not consistent with the Plan's Delivery System Rules.

Telehealth - Telehealth equipment, transmission charges or other non-medical technical charges associated with Telehealth services.

Temporomandibular Joint Disorder - Benefits are not provided for (a) any appliance or the adjustment of any appliance involving orthodontics; (b) any electronic diagnostic modalities; (c) occlusal analysis; (d) muscle testing; (e) splint therapy, and (f) biteguards.

Therapy - Speech therapy for lisps, articulation disorders (except with history of chronic otitis media), occlusion disorders; sensory integration therapy; biofeedback; gait training; range of motion exercise; language. Therapy for a diagnosis of lack of coordination. therapy; massage therapy; or for non-acute (chronic) therapy and maintenance care. Therapy for a diagnosis of lack of coordination.

Tobacco Cessation – Supplies or drugs related to the discontinuation of use of tobacco products.

Transplants - Organ Transplants, including services, supplies, or other care provided for organ and tissue transplants, except as listed in the Covered Services section for the diseases or conditions specifically listed in that section. Services and supplies related to a covered procedure received during the first nine (9) months after the Effective Date. In determining whether a pre-existing condition existed, the time the Participant was covered under any previous health plan will be credited if the coverage or combination of coverages totals 9 months and the previous coverage was continuous to a date not more than 63 days prior to the Participant's Effective date.

Travel/Transportation - Travel or transportation expenses (except Ambulance), even though prescribed by a Physician. Physical exams; administrative paperwork or cost of having forms completed; or immunizations performed for the purposes of employment, licensing, travel, school, insurance, marriage, adoption, participation in athletics.

Vision Therapy/Vision Exercises - Therapies or exercises prescribed or given for esotropia, exotropia, "lazy eye", "crossed eyes", refractive error, or disabilities/dysfunction of perception, reading or learning.

Voice Therapy/Speech or Voice Retraining - Voice exercises, voice therapy, voice retraining or any training or education for diagnoses including, but not limited to, "voice abuse" or "voice fatigue". Training such as voice therapy for conditions such as voice disorders without evidence of an anatomic abnormality, neurological condition, or injury are not covered. Speech or Voice therapy for any of the following situations are not covered as it is excluded from the benefit plan and considered not medically necessary when used for these purposes: 1) Any computer-based learning program for speech or voice training purposes; 2) School speech programs; 3) Speech or voice therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g. occupation therapy); 4) group speech or voice therapy (because it is not one-on-one, individualized to the specific person's needs); 5) maintenance programs of routine, repetitive drills/exercises that do not require the skills of a speech-language therapist and that can be reinforced by the individual or caregiver; 6) vocational rehabilitation programs and any programs with the primary goal of returning an individual to work; 7) therapy or treatment provided to prevent or slow deterioration in function or prevent reoccurrences; 8) therapy or treatment intended to improve or maintain general physical condition; 9) therapy or treatment provided to improve or enhance job, school, or recreational performance; 10) long-term rehabilitative services when significant therapeutic improvement is not expected.

War Injuries - Services, supplies, or other care for diseases or injuries sustained as a result of military service, war, declared or undeclared, or any act of war.

Workers' Compensation - Services, supplies or other care for any condition, disease, ailment or injury arising out of and in the course of employment if the covered person is engaged in any employment or occupation that is required under any Worker's Compensation Act or similar law to provide such coverage for employees. This exclusion applies if the Covered Person receives the benefit in whole or in part. This exclusion also applies whether or not the Covered Person claims the benefits or compensation. This exclusion also applies whether or not the Covered Person recovers from any third-party. After a final determination by the Board of Worker's Claims that the aforesaid injury is not work related, then this exclusion will not apply.

GENERAL PROVISIONS

1. ELIGIBILITY

Subscribers and their Dependents must meet the eligibility requirements of this Certificate and the Group Contract.

A. Subscriber:

To be a Subscriber you must:

1. Primarily reside in the UK-HMO Service Area (temporary absences from the service area with the intent to return within 120 days will not interrupt the Member's primary residence in the service area. Members experiencing absences from the service area for a period of 121 or more days, regardless of intent to return, are required to contact UK Employee Benefits to make arrangement for enrolling in an alternative benefit structure.)
2. Be eligible as outlined in the University of Kentucky Human Resources Policy and Procedure Number 93.0.
3. Complete, sign, and execute all enrollment forms and other documents as required.

B. Dependents:

To be a Dependent you must:

1. Primarily reside in the UK-HMO Service Area (temporary absences from the service area with the intent to return within 120 days will not interrupt the Member's primary residence in the service area. Members experiencing absences from the service area for a period of 121 or more days, regardless of intent to return, are required to contact UK Employee Benefits to make arrangement for enrolling in an alternative benefit structure.)
2. Meet the University of Kentucky's eligibility requirements for Dependent coverage.
3. Be the legal spouse of the Member; or
4. Be a Dependent child of a Member who satisfied the Definition of Dependent (refer to definition section)
5. Be a Child of a Sponsored Dependent who satisfied the Definition of Child of Sponsored Dependent (refer to definition section)
5. The Dependent age limit is up to age 26.

Newborns of Dependents are covered only if the Subscriber is the court-appointed guardian of the newborn. In this case, the subscriber must provide UK Employee Benefits with legal documentation.

C. Sponsored Dependent:

To be a Sponsored Dependent you must:

1. Primarily reside in the UK-HMO Service Area (temporary absences from the service area with the intent to return within 120 days will not interrupt the Member's primary residence in the service area. Members experiencing absences from the service area for a period of 121 or more days, regardless of intent to return, are required to contact UK Employee Benefits to make arrangement for enrolling in an alternative benefit structure.)
2. The Member must share the same household with the Sponsored Dependent.
3. Meet the University of Kentucky's eligibility requirements for Sponsored Dependent coverage.
4. Be a Sponsored Dependent of a Member who satisfied the Definition of Sponsored Dependent (refer to definition section).

It is your responsibility to notify the Employee Benefits Office if a Sponsored Dependent is no longer eligible for coverage or if the Sponsored Dependent obtains coverage from another employer.

C. Family and Medical Leave Act of 1993

A Subscriber who is on a period of leave under the Family and Medical Leave Act of 1993 (FMLA) may choose to continue coverage under the Plan for the period of leave under the Act. If the Subscriber decides not to continue coverage during the leave period, he/she and any eligible Dependents who were covered immediately before the leave may be reinstated upon return to work without an additional Waiting Period for Pre-existing Conditions.

1. ELIGIBILITY (cont.)

The Member is responsible to notify, in writing, the University of Kentucky Employee Benefits Office of any changes which will affect his or her eligibility or that of Dependents for services or benefits under this Certificate as soon as possible but no later than 30 days of the event. This includes changes in address, marriage, divorce, death, change of Dependent disability or dependency status, enrollment or dis-enrollment in another health plan or Medicare.

The Member and Dependent will be jointly and separately responsible for reasonable charges for any services or benefits provided under this Certificate after the Dependent ceases to be eligible for coverage.

2. ENROLLMENT AND EFFECTIVE DATES

A. Regular Enrollment

Each eligible employee of the Group must apply for coverage for self and eligible Dependents:

1. during the initial Group Open Enrollment; or
2. during the subsequent annual Open Enrollment period; or
3. when initially eligible as a new employee. New employees must apply for coverage within thirty (30) days of becoming eligible.

Persons who apply for coverage for themselves or their Dependents at any other time are eligible only if they qualify for Special Enrollment. Otherwise, they may apply during the next open enrollment period.

B. Qualifying Events for Special Enrollment

Eligible persons who did not enroll during Regular Enrollment must have a qualifying event to enroll before the next Open Enrollment. The following are qualifying events for Special Enrollment:

1. Mid-Year Loss of COBRA or Other Health Coverage: In this case, an eligible Employee or Dependent must have declined coverage with UK at the time of initial eligibility because he/she had other health coverage, but later loses that coverage. Application for coverage must be made within 30 days of the loss. To be qualified to enroll such person must have had coverage:
 - a. under a COBRA continuation provision and the coverage under such provision was exhausted; or
 - b. not under such a COBRA provision and either the coverage terminated as a result of loss of eligibility or employer contributions toward such coverage were terminated. Reasons for loss of eligibility include:
 - i. divorce
 - ii. death
 - iii. termination of employment or
 - iv. reduction in the number of hours of employment.

Coverage for a Special Enrollee who had other coverage and then lost it begins the day following the last date of coverage under the former Carrier. There is no lapse in coverage.

Individuals who lose other coverage for reasons not listed above, (e.g. nonpayment of premium or for cause) are not eligible for Special Enrollment.

2. Change in Family Status: An enrolled employee may enroll a newly acquired Dependent within 30 days of acquiring the new Dependent. This applies when the new Dependent is acquired through
 - a. marriage
 - b. birth
 - c. adoption or
 - d. placement for adoption, or court-ordered guardianship. Coverage for such Dependent begins as of the date of:
 - i. birth
 - ii. adoption or placement for adoption
 - iii. filing of the application for appointment of guardian or
 - iv. marriage.

C. Coverage of Newborns

Newborn children, when not enrolled as a Dependent, would be limited to coverage of routine nursery care up to 5 days for well newborns. For newborns requiring hospital care beyond routine nursery care, coverage would be up to 31 days (i.e. a newborn admitted to neonatal intensive care unit). If the Member submits a signed Enrollment Form within thirty (30) days of birth, the newborn would be covered with all dependent benefits.

3. REFUSAL TO ACCEPT TREATMENT

A Member may, for personal or religious reasons, refuse to accept procedures or treatment (care) recommended as necessary by a Provider. Although a Member has the right to refuse, it may be a barrier to the Physician-patient relationship or to appropriate care. If a Member refuses care and the Provider believes that no other acceptable course of care is appropriate, the Provider will inform the Member. If the Member still refuses the recommended care or requests a service that the Provider does not believe medically or professionally appropriate, the Provider is relieved of further professional responsibility to provide care. In addition, UK-HMO is relieved of further financial responsibility to arrange or pay for further care for the condition under treatment.

4. CLAIMS

You are not required to file claims for services from Participating Providers. The Plan makes payments directly to Participating Providers for Covered Services. All Participating Providers are required to accept payment directly from the Plan for Covered Services.

For services you receive from Non-Participating Providers, the Plan may pay the Provider directly, however, the Plan reserves the right to make payments directly to you for Non-Participating Provider services. Before the Plan pays a claim submitted by a Non-Participating Provider, we may require you to verify in writing that you received the services for which the claim was submitted. The Plan will send you a verification form. The Plan will pay for Covered Services from Non-Participating Providers only when:

1. A properly completed claim form is submitted for a Covered Services provided by a Non-Participating Provider; and
2. When required, you verify that you received the services for which the claim is submitted; and
3. The claim and any required verification is received within twelve months of the date of service; and
4. Services are pre-authorized (unless urgent or emergent).

A claim must contain adequate information to determine benefits. For emergency care from Non-Participating Providers, also send the emergency medical record.

You may request a claim form by calling Member Services. The Plan is not liable for claims received after one year from the date of service. If payment is due to a Member after the Member's death, the claim will be paid to the Member's estate.

After a claim is processed, the Plan will send you an Explanation of Benefits (EOB) if you are responsible for any amount other than a Co-payment. The EOB includes the amount paid by the Plan, the amount you are responsible to pay, and, if applicable, the reason for denial. Upon request, the Plan may send an EOB to an alternate address, a custodial parent or a designated representative.

Except in the case of fraud, the Plan will not honor a Member's request to withhold payment of any claims for Covered Services submitted by a Participating Provider. The Plan shall have no liability to any person because it rejects such request. The Plan's obligation to pay for Covered Services ends when the Plan pays a claim in accordance with the terms and conditions of the Contract. The Plan may pay claims that do not come within the specific benefits provisions of this Certificate. Such payment is not a precedent for setting similar claims in the future.

Inquiry, Complaint and Appeal - If you have a problem or complaint regarding any aspect of your benefits, or a claim payment or denial, you may contact Member Services to discuss the matter. If the matter is not resolved to your satisfaction, you may follow the Member Appeal Process described on pages 13 - 14.

Limitation of Actions - In order to appeal a denial under this plan, you must exercise your rights as set forth under the Member Appeal Process. It is to the Member's advantage to exhaust the Plan's administrative appeal process before instituting a separate legal action.

5. COORDINATION OF BENEFITS AND SUBROGATION

A. COORDINATION OF BENEFITS

Coordination of Benefits (COB) determines the way benefits should be paid when a person is covered under more than one health plan. COB establishes the order of payment and to avoid any double payment when two or more plans cover an individual. All of the health benefits provided under this Certificate are subject to COB.

In this section, “plan” means any plan providing medical care benefits under:

1. group coverage, or any other arrangement of coverage for individuals in a group other than franchised insurance;
2. coverage under any governmental plan (other than Medicaid) including -Workers’ Compensation and Medicare; or
3. individual coverage.

UK-HMO does not include

1. school accident-type coverage;
2. blanket insurance;
3. any governmental plan that by law provides benefits that are in excess of those of any private insurance program or
4. other non-governmental program; franchise insurance; or Medicaid.

“Claim determination period” means twelve consecutive months over which allowable expenses are compared with total benefits payable in the absence of coordination of benefits to determine whether over-insurance exists and how much each plan will pay or provide.

“Allowable expense” means a health care service or expense including

1. deductibles,
2. Coinsurance or Co-payments that is covered in full or in part by any of the plans covering the person.

You are required to inform UK-HMO and Providers of any coverage you may have under another health plan. You agree to assist and cooperate with UK-HMO in coordinating its payment for Covered Services with any other health plan that covers you.

When UK-HMO is secondary, benefits under this Plan are reduced so that the total benefits paid or provided by all plans during a claim determination period are not more than 100 percent of total allowable expenses. UK-HMO calculates any savings as a secondary plan by subtracting the amount it paid as secondary plan from the amount it would have paid had it been primary.

If your primary plan benefits are reduced by the primary plan because you did not comply with its utilization review requirements or for using out-of-network providers, the amount of the reduction is not an allowable expense for determining UK-HMO’s secondary plan liability.

B. RIGHT TO RECEIVE AND RELEASE INFORMATION

UK-HMO or its TPA may release to, or obtain from, any plan that covers you any information needed to administer this provision.

UK-HMO may pay to any organization any amounts it shall determine to be necessary to satisfy the intent of this provision. Organizations to whom such amounts may be payable may include:

1. insurance companies
2. persons or
3. state agencies or departments.

Any amount so paid will discharge UK-HMO from obligation under this Contract to the extent of such payment. UK-HMO has the right to recover any payments it has made in excess of the maximum amount payable in accordance with this provision.

C. DETERMINATION RULES

When this plan and one or more other plans cover a Member, the requirements for determining the order of benefit payments are as follows:

1. The primary plan shall pay or provide its benefits as if the secondary plan or plans did not exist;
2. A plan that does not coordinate benefits consistent with Kentucky regulation 806 KAR 18:030 is always primary, with one exception. If coverage is obtained by virtue of membership in a group and supplements a part of a basic package of benefits, the supplementary coverage may be considered secondary to the basic package of benefits provided by the contract holder; and
3. A plan may take the benefits of another plan into account only when it is secondary to that other plan.

The first of the following requirements that describes which plan pays its benefits before another plan is the requirement to use:

1. Nondependent or dependent:

The plan that covers the person other than as a dependent is primary and the plan that covers the person as a dependent is secondary unless the person is a Medicare beneficiary, in which case the order of benefits is determined in accordance with 42 USC 1395.
2. A child, including a newborn subject to KRS 304.17-042 and 30418-032, covered under more than one (1) plan.
 - a. The primary plan is the plan of the parent whose birthday is earlier in the year if:
 - i. The parents are married;
 - ii. The parents are not separated (whether or not they ever have been married) or
 - iii. A court decree awards joint custody without specifying that one (1) parent has the responsibility to provide health care coverage
 - b. If both parents have the same birthday, the plan that has covered either of the parents longer is primary
 - c. If a court decree states that one parent is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's spouse does, the spouse's plan is primary.
 - d. If the parents are not married or are separated or divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit s determination among the plans of the parents and the parents' spouses (if any) is:
 - i. The Plan of the custodial parent;
 - ii. The Plan of the spouse (stepparent) of the custodial parent;
 - iii. The Plan of the non-custodial parent; and then
 - iv. The plan of the spouse of the non-custodial parent
3. Active/Inactive Employees

A plan that covers a person as an employee who is neither laid off nor retired, or as that employee's Dependent, is primary.
4. Continuation Coverage

If a person has coverage under a continuation provision by law and is also covered under another plan, the plan covering the person as

 - a. an employee,
 - b. Member, subscriber or
 - c. retiree, or as that person's dependent, is primary and the continuation coverage is secondary.

C. DETERMINATION RULES (Cont.)

5. Longer/Shorter length of Coverage

If none of the above rules determine the order of benefits, the plan that covered the Member longer is primary.

- a. To determine the length of time a person has been covered under a plan, two plans shall be treated as one (1) if the Member was eligible under the second within 24 hours after the first ended;
 - b. Changes during a coverage period that do not constitute the start of a new plan include:
 - i. a change in scope of a plan's benefits;
 - ii. a change in the entity that pays, provides or administers the plan's benefits; or
 - iii. a change from one type of plan to another.
 - c. The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a Member of the group shall be used to measure length of coverage.
6. If none of the above determines the primary plan, the allowable expenses shall be shared equally between the plans.

D. SUBROGATION AND REIMBURSEMENT

"Subrogation" is the legal right that allows the Plan to obtain reimbursement from certain other persons or entities for the costs of care or services paid by UK-HMO. "Reimbursement" is the legal right that allows UK-HMO to proceed directly against the Member. When subrogation or reimbursement apply, the rights of the Member to claim or receive compensation, damages, or other payment from the other party or parties is transferred to UK HMO, but only to the extent of UK HMO's Allowed Amount for the benefits received by the Member.

"Made Whole" Rule Waived

Under Kentucky law, unless there is an agreement to the contrary, the Member must be fully compensated, "made whole," for all injuries or losses sustained before UK-HMO's subrogation or reimbursement rights arise. In consideration of the benefits provided by UK-HMO, Member agrees to modify and waive the "made whole" rule according to the terms of this Section. This agreement provides UK-HMO with a first priority right to recover its costs of care or services provided without regard for whether the Member is fully compensated for all losses.

Subrogation

If a Member is injured or becomes ill and any other person or entity is or may be liable to the Member for the cost of resultant medical services or supplies that are Covered Services under this Certificate, UK-HMO shall be subrogated, in first priority, to the Member's right to recover from such other party. UK-HMO's subrogation right is without regard for whether the Member has been fully compensated for all losses. UK-HMO shall have the right to pursue any legal method to obtain payment from any other party. Other persons and entities who may be liable include, but not limited to, an Uninsured Motorist, Underinsured Motorist, Medical Payments (auto, homeowners' or otherwise) or Workers' Compensation insurer.

Reimbursement

If the Member receives any money from settlement, judgment, or other source from any other party, the Member agrees to reimburse UK-HMO, in first priority, immediately upon receiving the funds, for all Covered Services provided under this plan for care and treatment of such injury or illness, up to the Allowed Amount for such Covered Services. Other parties include, but not limited to, an Uninsured Motorist, Underinsured Motorist, Medical Payments (auto, homeowners' or otherwise) or Workers' Compensation insurer.

Subrogation (Cont.)

Reimbursement (Cont.)

This agreement applies to such settlement monies, regardless of how those funds or amounts are characterized. Payment is due to UK-HMO without regard for whether the Member had been fully compensated for all losses. The Member grants UK-HMO a first lien against any and all sums received, set aside, or owed to Member. The lien granted under this Section shall be superior to, and exclusive of, any claims for attorney's fees for a Member's attorney and UK-HMO shall not be responsible for any portion of such fees.

Notice and Cooperation

The Member agrees to immediately notify UK-HMO of any offer or payment, and to take such action, furnish such information and assistance, and execute or do any other act necessary to protect UK-HMO's right under this Section. If the Member fails to abide by the terms of this Section, UK-HMO may terminate that Member in accordance with Section VI.

E. WORKERS' COMPENSATION

The benefits under this Certificate do not duplicate any benefit the Member is eligible to receive under Workers' Compensation Insurance. If the Plan pays for benefits that are later determined to have been properly payable by a Workers' Compensation policy, all sums payable pursuant to that policy for such benefits shall be payable to and retained by the Plan up to the amount paid by the Plan. Coverage under this Certificate is not in lieu of, and shall not affect, any requirement for coverage under Workers' Compensation.

6. TERMINATION OF COVERAGE

A. REASONS FOR TERMINATION

UK-HMO will terminate coverage for any of the following reasons, subject to any applicable Continuation benefit rights a Member may have:

1. Nonpayment of premium by or on behalf of a Subscriber, or UK-HMO has not received timely premium payment.
2. The Member has performed an act that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the Plan. The Member is responsible for all costs incurred by the Plan as a result of the misrepresentation.
3. The Member has engaged in intentional and abusive noncompliance with material provisions of this health benefit plan. Noncompliance material provisions by the Member include, but not limited to:
 - a. Repeated failure to pay applicable Co-payments or Coinsurance;
 - b. failure to cooperate with the Coordination of Benefits or Subrogation provisions of this Certificate;
 - c. the inability to maintain a reasonable provider-patient relationship; , or
 - d. other conduct which prevents the Plan or Provider from providing service to the Member or other enrollees in a reasonable manner.
 - e. Permitting another person to falsely use one's Plan identification (ID) card. The card may be retained by the Plan and coverage of the Member terminated. The Member is liable to the Plan for all costs incurred as a result of the misuse of the ID card.
 - f. If a Member engages in theft or destruction of property of the Plan, a Plan employee or Participating Provider. Such acts include but are not limited to theft, misappropriation or alteration of prescription drug ordering forms), or if a Member threatens to or actually does physically harm a Plan employee, a Participating Provider or Provider's staff.

6. TERMINATION OF COVERAGE (Cont.)

4. Dependent child. A Dependent child's enrollment will be terminated upon the earliest of any of the following occurrences:
 - a. The Dependent's date of marriage;
 - b. Attainment of the applicable limiting age in the Contract, except as otherwise provided in subsection 4(c) below;
 - c. Determination that the child, who had become totally disabled prior to attaining a limiting age in the Contract and whose disability had continued beyond such limiting age, is no longer totally disabled;
 - d. Valid termination of the Subscriber's coverage; or
 - e. The last day of the month in which the individual otherwise no longer qualifies as a Dependent. 5. Spouse. Coverage for a spouse will terminate on the date the Subscriber is legally divorced from his or her spouse, or upon termination of the Subscriber's coverage.

Termination of the UK Medical Benefits Plan automatically terminates all your coverage as of the date of termination. It is the responsibility of the University of Kentucky to notify you of the termination of the coverage. However, the coverage will be terminated, regardless of whether the notice is given.

B. CERTIFICATION OF CREDITABLE COVERAGE

The Plan will provide written certification of the period of Creditable Coverage, as defined in this Certificate, under this Plan, in the following circumstances:

1. At the time an individual ceases to be covered under this Plan or otherwise becomes covered a under COBRA continuation provision;
2. In the case of an individual who became covered under a COBRA provision, at the time the individual ceases to be covered under that provision; and
3. If requested on behalf of an individual if the request is made not more than 24 months after the date the coverage described above in (1) or (2) ceases, whichever is later.

C. EXTENSION OF BENEFITS

If you are Totally Disabled at the time the UK Medical Benefits Plan terminates, we will extend coverage for your disabling condition as stated below:

For hospital confinement, this extension ends upon the earlier of one of the following:

1. discharge from the hospital;
2. maximum benefits under this Certificate are received; or
3. twelve months.

For Total Disability this extension ends upon the earlier of one of the following:

1. coverage for the Total Disability has been obtained under another group policy;
2. the Total Disability ceases;
3. maximum benefits under this Certificate are received; or
4. twelve months.

The extension of benefits applies only to the Member who is confined in a Hospital or Totally Disabled. To obtain this coverage you must submit a written request for this extension of benefits within thirty-one (31) days of the date your coverage would otherwise terminate under this Certificate, together with proof of your total disability.

Extended benefits will be subject to all the applicable conditions of your Certificate.

7. CONTINUATION OF GROUP COVERAGE

A. Consolidated Omnibus Reconciliation Act (COBRA)

Effective July 1, 1986, generally employers of 20 or more employees during the preceding calendar year must provide for the continuation of coverage for “qualified beneficiaries” upon the occurrence of “qualifying events”. These terms are defined as follows:

Qualified Beneficiary:

- A covered employee.
- A covered spouse or Dependent child of an employee, including a child born to, or placed for adoption with, the covered employee during the period of COBRA coverage.

Qualifying Events - means with respect to any covered employee, any of the following events which would result in the loss of coverage of a qualified beneficiary:

- Termination of employment (for reasons other than gross misconduct) of the employee or a reduction in hours worked. (up to 18 months of continued coverage; 29 months in the case of disability)
- Dependent child ceases to be a Dependent child under the generally applicable requirements of the Plan. (up to 36 months of continued coverage)
- Death of a covered employee. (up to 36 months of continued coverage)
- The divorce or legal separation of a covered employee from the employee’s spouse. (up to 36 months of continued coverage)
- The covered employee becoming entitled to benefits under Title XVIII of the Social Security Act (i.e., Medicare) (up to 36 months of continued coverage).
- A bankruptcy proceeding with respect to the employer from whose employment the covered employee retired at any time.

Under the law, the employee or a family member has the responsibility to inform the Plan Administrator of a divorce, legal separation or a child losing Dependent status within 60 days of the date of the event. The law generally allows an 18 month continuation of coverage period in the event of termination of employment or a reduction in hours worked (except for reason of disability which allows 29 months of continuation coverage) and 36 months for most other qualifying events. The 18-month continuation of coverage period may be extended for affected individuals up to 36 months from termination of employment if other events (such as a death, divorce, legal separation, or Medicare entitlement) occur during the 18-month period.

Qualified beneficiaries who are determined to be disabled under the Social Security Act at any time during the first 60 days of COBRA continuation coverage will be able to purchase an additional 11 months of coverage beyond the usual 18 month coverage period at a higher premium rate. This extension of coverage is also available to non-disabled family members who are entitled to COBRA continuation coverage. To benefit from this extension, a qualified beneficiary must notify the Plan Administrator of that determination within 60 days and before the end of the original 18-month continuation coverage period. The affected individual must also notify the Plan Administrator within 30 days of any final determination that the individual is no longer disabled.

COBRA coverage will terminate on the earlier of the following:

1. Coverage ceases upon expiration of the 18, 29 or 36 month continuation period, is whichever applicable; or
2. Failure to pay premium on a timely basis; or
3. The qualified beneficiary becomes covered under another group health plan and the new plan does not contain any exclusion or limitations with respect to any Pre-existing Condition; or
4. Medicare entitlement of the “qualified beneficiary”; or
5. The qualified beneficiary has extended coverage for an additional 11 months due to disability and there has been a final determination that the individual is no longer disabled.

7. CONTINUATION OF GROUP COVERAGE (Cont.)

Requirements:

COBRA requires employers to notify their employees in writing of their continuation of coverage rights when group health coverage begins. The employer must notify Qualified beneficiaries of their benefits within 14 days of a qualifying event. An election period of not less than 60 days from the occurrence or date of notification of the qualifying event, must be offered to all qualified beneficiaries.

COBRA premiums are 102 percent of the then applicable Group rate. Premium payment is due within 45 days of the initial COBRA election. All future premiums must be submitted on a timely basis (within 30 days of a due date) to avoid termination of continuation of benefits.

In order to obtain COBRA coverage under this Certificate, the Member must:

- Notify employer of the qualifying event and obtain appropriate forms to complete for COBRA election.
- Request COBRA coverage in writing to the employer before the later of 60 days from the date of notification of the qualifying event or the occurrence of the qualifying event.
- Pay the first applicable premium to the employer within 45 days of the election date, and pay the remaining premiums to the Plan within 30 days of the due date.

If you do not choose continuation coverage on a timely basis, your Group health insurance coverage will end. If you choose continuation coverage, you must receive coverage, which, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated employees or family members.

8. MISCELLANEOUS

Privacy

UK-HMO protects your health information. UK-HMO's privacy policies comply with all laws and regulations. Your health information will not be given out without your authorization, except as allowed by law or regulation. UK-HMO uses your health information to provide benefits under this Certificate.

You agree that UK-HMO and its business associates may receive health information from Providers or others to determine benefit coverage. UK-HMO will not provide benefits when needed information is not available.

You agree that the Plan may release information about your condition to another Carrier that covers you. The Plan will not release information about mental health, chemical dependency and genetic tests without your authorization.

Member Hold Harmless Provision

The following rules appear in contracts between the Plan and Participating Providers. It prohibits these Providers from charging Members more than is due under the terms of the Plan. This applies to all Covered Services you receive from a Participating Provider while enrolled in UK-HMO. This provision is always to your benefit.

- A Provider may only collect from you Coinsurances, Co-payments and Deductibles stated in this Certificate. You pay charges for services excluded under this Certificate.
- A Provider may not bill or charge you if the Plan fails to pay the Provider for any reason.
- If the Plan denies benefits based on Medically Necessity, a Provider may not bill or collect payment from you.
- A Provider may not bill you for any amount above the fees the provider agreed to accept as payment in full.
- If you and a Provider agree that non-Covered Services will be provided, the Provider may charge you only if you agree in advance to pay for the service. This does not apply to services denied as not Medically Necessary.

Portability - UK-HMO will comply with the portability rules of the Federal and State Law.

Identification (ID) Card - An ID card is issued to Members for identification purposes only. You must present the ID card when seeking Covered Services. An ID card does not confer a right to benefits under this Certificate. To be entitled to benefits you must be enrolled and have Premiums paid. Persons receiving services for which they are not eligible will incur charges for those services. The ID card is the property of UK-HMO. UK-HMO may request return of an ID card at any time. Immediately report loss or theft of an ID card to the Plan.

Non-discrimination Requirements - Individuals may not be excluded from coverage or charged more for coverage based on health status.

Assignment - The Member may not assign his or her rights, including the right to receive benefits for Covered Services, under this Certificate.

Contract Administration - The Plan adopts policies and procedures to administer the provisions of your Certificate. The policies and procedures are binding upon you to the same extent as stated in your Certificate. We may obtain advisory opinions from professional consultants in making a decision on claims.

UK-HMO or anyone acting on its behalf has full authority and discretion to interpret, administer and enforce all Plan provisions. This includes, without limitation,

- A. determinations of Medical Necessity,
- B. determination that a service is Experimental or Investigational,
- C. determination that a service is cosmetic surgery,
- D. eligibility for benefits and coverage, or
- E. whether charges are reasonable.

A Member may use the Member Appeals Process if they disagree.

UK-HMO or anyone acting on its behalf shall have all the powers necessary or appropriate to enable it to carry out its duties in connection with the administration of this Certificate. This includes, without limitation, the power:

- A. To construe the Contract;
- B. To determine all questions arising under the Certificate; and
- C. To make, establish and amend the rules and regulations and procedures with regard to the interpretation and administration of the provisions of this Certificate.

A specific limitation or exclusion will override more general benefit language.

Change of Address - The Member must promptly notify the University of Kentucky Employee Benefits Office of a change of address or the address of a Dependent. Coverage will be canceled as of the date that the Member no longer lives or works in the Service Area.

Clerical Error - A clerical or administrative error by the Plan will not invalidate coverage otherwise validly in effect nor continue coverage otherwise not validly in effect.

Severability - Any provision in this Certificate declared legally invalid by a court of law will be severable. All other provisions of the Certificate will remain in full force and effect.

Right of Recovery - The Plan has the right to recover from you any payments made in error to you or, if applicable, to the Provider. The Plan reserves the right to deduct or offset any amounts paid in error from any pending or future claim for up to two years after the date that the Plan paid the claim. If the Plan pays for any service rendered after your termination date, the Plan shall have the right to recover payments.

Provider Relationship - The Plan contracts with certain Providers called “Participating Providers.” The relationship between the Plan and Participating Providers is that of independent contractors. Participating Providers are not agents or employees of the Plan, nor is the Plan an employee or agent of Participating Providers. The Plan is not liable for any act or omission of any Provider. This Certificate does not give anyone any claim, right or cause of action based on what any Provider of health care or supplies does or does not do.

Notice - Any notice from the Plan to the Member will be deemed appropriately given if:
A. In writing; and B. Personally delivered, deposited in the United States Mail with postage pre-paid and addressed to the Member at the most recent address provided to the Plan in writing by the Member or Group, or,

Headings - The heading and captions in this Certificate are not a part of this Certificate and exist only for purposes of convenience.

Execution of Certificate of Coverage - The parties acknowledge and agree that the Member’s signature or electronic signature on the Enrollment form will be deemed execution of this Certificate. By electing coverage or accepting these benefits, all Members legally capable of contracting agree to all terms, conditions and provisions of this Certificate for themselves and any covered Dependents.

Waiver or Modification - No waiver, modification or change to this Certificate is effective unless and until approved in writing by an officer of UK-HMO. Any such change will be evidenced by an endorsement to this Certificate.

Major Disasters - In the event of a major disaster, epidemic or other circumstances beyond its control, the Plan will make a reasonable attempt to provide benefits for Covered Services. The Plan will do so according to its best judgment and within the limitations of facilities and personnel then available. However, the Plan incurs no liability or obligations for the delay or failure to provide services due to lack of available facilities or personnel, if the lack is the result of circumstances beyond the Plan’s control. Such circumstances include complete or partial disruption of facilities, war, riot, civil insurrection, labor disputes not within the control of the Plan or similar causes. The Plan requires that federal funds be recovered if applicable.

University of Kentucky Prescription Drug Benefit Program
Summary Plan Description

Introduction
Definitions
Services and Benefits
Limits to Covered Prescription Drug Benefit
Excluded Prescription Drugs
Member Appeals Process
Contact Information
Termination of Coverage

INTRODUCTION

The Prescription Drug Benefit Program is available to UK employees, UK early retirees and dependents that are enrolled as plan participants in the UK-HMO, UK-PPO, UK-EPO, UK-RHP, or the UK-Indemnity Health Plan options. There is one universal prescription benefit that is administered directly by the University instead of through the medical plans. Enrollment in the prescription drug benefit program is automatic with the Member's enrollment on any of the UK Health Plans. The Member will have a separate prescription drug benefit identification card from Express Scripts which must be presented to the pharmacist at the time of service. A ten-digit ID number (not the social security number) is assigned to the plan member. If the plan member has a covered spouse and/or dependent(s), this same ten-digit ID is used for each respective plan participant, with a different two-digit suffix (i.e. plan member - "00", spouse/dependent - "01", etc.)

Prescription drug benefits are payable for covered prescription expenses incurred by the Member and the Member's covered dependents. Benefits are payable for such expenses for charges made by a participating pharmacy for each separate prescription, subject to the applicable co-payment or coinsurance as shown in the Schedule of Benefits.

Express Scripts is the pharmacy benefit manager.

How to fill your prescription:

- At your local participating pharmacy: You will be able to obtain your immediate need (30-day supply) prescriptions through Express Scripts national network of chain and independent retail pharmacies.
- Through Express Scripts Mail Service Pharmacy: You will be able to receive your chronic need medications (up to a 90-day supply) by mail service. Your medications will be delivered free of shipping costs within two weeks. You will be charged for overnight or two-day delivery when you request such service. You will be able to track these prescriptions on the Express Scripts Web site, and can reorder them by phone, mail or online (www.express-scripts.com).
- Through Kentucky Clinic Pharmacy: You will be able to obtain both your immediate need (30-day supply) prescriptions AND your chronic need (up to 90-day supply) prescriptions at the Kentucky Clinic Pharmacy ONLY if these prescriptions have been written by a UK prescriber.

DEFINITIONS

Ancillary Charge: A charge in addition to the Co-payment / Coinsurance which the member is required to pay to a Participating Pharmacy for a covered Brand name Prescription Drug Product for which a Generic substitute is available. The Ancillary Charge is calculated as the difference between the Pharmacy Payment Rate for the Brand name Prescription Drug Product dispensed and the Maximum Allowable Cost (MAC) of the Generic substitute.

Average Wholesale Price (AWP): The standardized cost of a drug product, calculated by averaging the cost of an undiscounted drug product charged to a drug wholesaler by a pharmaceutical manufacturer. AWP is as shown in the Express Scripts drug price file and as generally determined by "First Databank".

Brand: A patent-protected Prescription Drug Product that is manufactured and marketed under a trademark, proprietary or non-proprietary name by a specific drug manufacturer. (When manufacturers create new medications, they apply for a patent. After the patent expires, the FDA may approve other manufacturers to produce generic equivalents of the drug.)

Chemical Equivalents: Multiple-source drug products containing essentially identical amounts of the same active ingredients, in equivalent dosage forms, and which meet existing FDA physical/chemical standards.

Coinsurance: The percentage of the eligible expense for each separate prescription order or refill of a covered drug when dispensed by a participating pharmacy. The percentage coinsurance is based on the Pharmacy Payment rate if the Member utilizes a Participating Pharmacy and the Pharmacy submits the claim to Express Scripts electronically. The Member is responsible for payment of the Coinsurance at the point of service. Coinsurance may also be known as a percentage Co-payment.

Compound Drug: A drug prepared by a pharmacist using a combination of drugs in which at least one agent is a legend drug. The final product is typically not commercially available in the strength and/or dosage form prescribed by the physician.

Co-pay (Co-payment): The amount to be paid by you toward the cost of each separate prescription order or refill of a covered drug when dispensed by a participating pharmacy. A "flat dollar" Co-pay is a fixed dollar amount paid by the member when the prescription is filled. The member's Co-payment for a covered drug at a Participating Pharmacy shall be the lesser of the applicable Co-payment or the pharmacy submitted usual and customary charge. The Member is responsible for payment of the Co-pay at the point of service. Coinsurance may also be known as a percentage Co-payment.

Dependents: The individuals (usually spouse and children) that are included in the primary cardholder's benefit coverage.

Dispense as Written (DAW): A physician directive not to substitute a product.

Express Scripts CuraScript Program: a specialty pharmacy management program specializing in the provision of high-cost biotech and other injectable drugs. Express Scripts defines specialty injectable drugs in this category as injectable drugs that have an AWP of \$500 or greater per 30 day prescription.

Formulary: A formulary is a clinically-based drug list that contains FDA-approved brand-name and generic drugs. Formularies are developed based on clinical attributes, as well as cost-effectiveness of products. Members will get the greatest value from their prescription drug benefit when they receive generic or brand-name drugs that are on the formulary. A formulary may also be referred to as a preferred drug list.

DEFINITIONS (continued)

A copy of the University of Kentucky Formulary is on-line at <http://www.uky.edu/HR/benefits/prescriptionoverview.html> or by calling University of Kentucky Employee Benefits.

Formulary Brand: A brand-name drug that is listed on your formulary. It may also be referred to as a preferred brand drug.

Formulary Drug: A drug that is listed on your formulary, It may also be referred to as a preferred drug.

Generic: A drug that is chemically equivalent to a brand drug for which the patent has expired. The color and shape of the drug may be different, but the active ingredients are the same. Generic medications are required to meet the same quality standards as brand drugs.

Investigational: Any drug, device, supply, treatment, procedure, facility, equipment or service that is being studied to determine if it should be used for patient care or if it is effective. Something that is Investigational is not recognized as effective medical practice. We reserve the sole right to determine what Investigational is. Approval by the Food and Drug Administration (FDA) does not mean that we approve the service or supply. Drugs classified as Treatment Investigational New Drugs by the FDA are Investigational. Devices with the FDA Investigational Device Exemption and any services involved in clinical trials are Investigational.

Legend Drugs: A drug that can be obtained only by prescription order and bears the label “Caution: federal law prohibits dispensing without a prescription.”

List of Drugs: See Formulary.

Local Pharmacy: See Participating Pharmacy.

Maximum Allowable Cost (MAC list): A maximum reimbursement amount. It is a list of Prescription Drug Products covered at a Generic product price. The MAC list applies to certain generic drug prescription products, but it also applies (under certain conditions) to multi-source products depending upon the DAW code submitted with the claim. This list is distributed to Participating Pharmacies and is subject to periodic review and modification.

Mail Pharmacy: A pharmacy that provides long-term supplies of maintenance medications via mail. Members usually pay less for these medications than they would if obtained from a local participating pharmacy.

Mail Service Benefit: A benefit that allows members to order long-term supplies of maintenance medications via mail. Members usually pay less for these medications than they would if obtained from a local participating pharmacy.

Maintenance medication: Prescription drugs, medicines or medications that are generally prescribed for treatment of long-term chronic sickness or bodily injuries, and, purchased from the pharmacy contracted by the Plan Manager to dispense drugs.

Member: An individual eligible for benefits under the Plan as determined by University of Kentucky Employee Benefits.

Member-Submitted Claims: Paper claims submitted by a Member for Prescription orders or refills at a Participating Pharmacy when the claim is not processed on-line electronically by Express Scripts (e.g., when eligibility cannot be verified at the point of service); such claims are to be reimbursed based on the Member Payment rate, adjusted for Co-pay, Coinsurance and Ancillary Charges.

DEFINITIONS (continued)

Multi-source Brand: A brand-name medication for which there is a chemically equivalent product available.

Non-Covered Drugs: Drugs excluded from coverage include but are not limited to: drugs which can be purchased without a written prescription (over the counter drugs), non-FDA approved and experimental (investigational) drugs, medications used exclusively for cosmetic purposes, medications used in the treatment of a non-covered diagnosis (benefit) such as weight loss, sexual dysfunction, and infertility, medications not for self-administration. Replacement of lost or stolen medications is not covered.

Non-Participating Pharmacy: A pharmacy which has not entered into an agreement with the Plan Manager to participate as part of the Express Scripts Pharmacy Network.

Non-Formulary Brand: A brand-name drug that is not listed on your formulary. Also referred to as a non-preferred brand drug.

Non-Preferred Brand: Drugs found not to have a significant therapeutic advantage over the Preferred drug. Also referred to as a non-formulary brand drug.

Over-the-counter (OTC) drug: A drug product that does not require a Prescription Order under federal or state law.

Out-of-Network Coverage: Your pharmacy benefit program does not allow for out-of-network coverage.

Participating Pharmacy: A pharmacy that has contractually agreed to provide prescription drug products to eligible members of a prescription benefit plan. Members must purchase their prescription drugs from a participating pharmacy to receive the coverage provided by the prescription benefit. The pharmacy will accept as payment the Co-payment / Coinsurance amount to be paid by you and the amount of the benefit payment provided by the Plan.

Participant: any covered person, who is properly enrolled in the Plan.

Pharmacist: a person who is licensed to prepare, compound and dispense medication and who is practicing within the scope of his or her license.

Pharmacy and Therapeutics (P&T) Committee: An organized panel of physicians and pharmacists from varying practice specialties, who function as an advisory panel to the Express Scripts benefit programs regarding the safe and effective use of prescription medications.

Pharmacy Payment Rate: The payment a Participating Pharmacy is entitled to receive, including any dispensing fee, for a particular Prescription Drug Product dispensed to a Member according to the terms of the applicable pharmacy provider contract, when the claim is processed on-line electronically by Express Scripts (or, on an exception basis, a Participating Pharmacy is allowed to submit paper claims to Express Scripts).

Plan Administrator: the University of Kentucky.

Plan Manager: see Prescription Benefit Manager.

Plan Year: A period of time beginning on the Plan anniversary date of any year and ending on the day before the same date of the succeeding year.

DEFINITIONS (continued)

Preferred Brand Drug: A brand-name drug that is listed on your formulary. It is also referred to as a formulary brand drug.

Preferred Drug – A drug that is listed on your formulary. It is also referred to as a formulary drug.

Prescription: A direct order for the preparation and use of drug, medicine or medication. The drug, medicine or medication must be obtainable only by prescription. The order must be given verbally, in writing, or by e-script by a qualified practitioner (prescriber) to a pharmacist for the benefit of and use by a covered person. The prescription must include

- Name and address of the covered person for whom the prescription is intended
- Type and quantity of the drug, medicine or medication prescribed, and the directions for its use.
- Date the prescription was prescribed
- Name, address and license number of the prescribing qualified practitioner

Prescription Benefit Manager (PBM): Express Scripts. The PBM provides services to the Plan Administrator, as defined under the Plan Management Agreement. The Plan Manager is not the Plan Administrator.

Prescription Drug Product: A medication, product or device approved by the FDA and dispensed under federal or state law only pursuant to a Prescription Order or Refill. This definition also includes insulin and certain diabetic supplies if dispensed pursuant to a Prescription Order or Refill.

Prescription Order or Refill: The directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

Prior Authorization: The required prior approval from the Plan Manager for the coverage of prescription drugs, medicines, medications, including the dosage, quantity and duration, as appropriate for the covered person's age and sex. Certain prescription drugs, medicines or medications may require prior authorization.

Single-Source Brand: A brand medication for which there is no generic version available.

Therapeutic Equivalent: A medication that can be expected to have the same clinical effect and safety profile when administered under the conditions specified in labeling as another medication, although the medications are not Chemical Equivalents.

Usual and Customary (U&C) Charge: The usual and customary price charged by a pharmacy for a Prescription Drug Product dispensed to a cash paying customers.

SERVICES AND BENEFITS

Schedule of Benefits

	1-month supply local pharmacy co-insurance	1-month supply local pharmacy minimum	1-month supply local pharmacy maximum	3-month supply mail service or KY Clinic Pharmacy co-insurance	3-month supply mail service or KY Clinic Pharmacy minimum	3-month supply mail service or KY Clinic Pharmacy maximum
Generic	20%	\$8.00	\$50.00	10%	\$24.00	\$100.00
Formulary Brand	40%	\$20.00	\$60.00	30%	\$60.00	\$120.00
Non-Formulary Brand	50%	\$40.00	\$100.00	40%	\$120.00	\$200.00

Retail Prescription Program

Drugs that are prescribed for short-term use (up to a 30-day supply) should be filled using the retail drug card. The Retail Prescription Drug Card Program is administered by Express Scripts. Participants are provided a prescription drug card to purchase drugs from a local pharmacy that participates in the Express Scripts Network. This network includes over 53,000 pharmacies nationwide. These include most chain or grocery stores such as Wal-Mart or Kroger as well as many independent pharmacies across the nation. Confirmation of participating pharmacies may be obtained by calling Express Scripts at 1-877-242-1864 or through the web site at www.express-scripts.com.

The amount of the coinsurance or co-payment is dependent upon whether the prescription is for a generic, a formulary brand name drug or a non-formulary brand name drug. A generic drug is identical in chemical composition to its brand name counterpart, has been approved by the Food and Drug Administration to be therapeutically equivalent, and is as effective as the brand name product. The use of generics and formulary brand name drugs help to keep the cost of prescription drugs down for both the participant and the plan. All non-formulary drugs have alternatives available; preferred brand name drugs and possibly generics, both of which are more, cost effective.

As a participant in this program, you must pay for:

- The cost of medication not covered under the prescription benefit;
- The cost of any quantity of medication dispensed in excess of a consecutive 30-day non-maintenance medication supply.

A copy of the University of Kentucky Formulary is on-line at http://www.uky.edu/HR/benefits/prescription_overview.html or by calling University of Kentucky Employee Benefits.

SERVICES AND BENEFITS (continued)

The Co-payments or Coinsurance for each type Retail (30-day) prescription at your local participating pharmacy are:

- Generic: 20% or minimum of \$8.00
- Formulary Brand Name Drug: 40% or minimum of \$20.00
- Non-Formulary Brand Name Drug: 50% or minimum of \$40.00

The out of pocket maximum is \$50 per generic prescription and \$60 for formulary brand name drugs (excluding non-formulary drugs which are subject to an out-of-pocket limit of \$100 per prescription). There is a mandatory generic program. If the Member does not accept the generic equivalent for a "brand name" drug when one exists, the Member will be responsible for the applicable brand name Co-pay or coinsurance, plus any cost difference between the brand name and generic drug up to the retail price of the requested drug.

Each retail prescription is limited to a 30-day supply. However if the medical condition is such that the prescription drug is to be taken over a prolonged period of time (month or even years) it may be more financially advantageous to use the mail order program described below.

Reimbursement for prescriptions purchased at non-network pharmacies will not be reimbursed under your prescription benefit, and are the financial responsibility of the Member.

All paper claims incurred during the calendar year must be submitted within 120 days of the original date of service. Any claims received after that date will be denied.

Pharmacy benefit Co-payments and Coinsurance cannot be applied toward the deductibles or out-of-pocket limits of the medical plans (UK-HMO, UK-PPO, UK-EPO, UK-RHP, or UK-Indemnity).

Mail Service Prescription Program

The mail order program is designed for individuals who take the same medication over a long period of time for conditions such as diabetes, high blood pressure, ulcers, emphysema, arthritis, heart or thyroid conditions. While it is not mandatory to use the mail order program, those that do may reduce their out of pocket payments and will not have to reorder as frequently.

The Co-payments or Coinsurance for each type Mail Service prescription (for a 1 to 34 day supply) are the same as outlined under the Retail Prescription Program above.

The Co-payments or Coinsurance for each type Mail Service prescription (for a 35 to 90-day supply) are:

- Generic: 10% or minimum of \$24.00
- Formulary Brand Name Drug: 30% or minimum of \$60.00
- Non Formulary Brand Name Drug: 40% or minimum of \$120.00

The out of pocket maximum is \$100 per generic prescription and \$120 per formulary brand name prescription (excluding non-formulary drugs which are subject to an out-of-pocket limit of \$200 per prescription). There is a mandatory generic program. If the Member does not accept the generic equivalent for a "brand name" drug when one exists, the Member will be responsible for the applicable brand name Co-pay or Coinsurance, plus any cost difference between the brand name and generic drug up to the retail price of the requested drug.

SERVICES AND BENEFITS (continued)

Each mail service prescription is limited to a maximum quantity limit of a 90-day supply. Express Scripts is required by law to dispense the prescription in the exact quantity specified by the physician. Therefore if the quantity prescribed is for less than 90 days per refill Express Scripts will fill that exact quantity.

To place an initial order through the mail service drug program a Mail Service Enrollment Order Form must be completed and submitted to Express Scripts along with the original prescription(s) and the appropriate payment. Order forms for the mail service prescription drug program are available from Express Scripts or the University of Kentucky Employee Benefits.

Refills for maintenance medications through the mail order pharmacy can be obtained by phone at 1-877-242-1864, or through the Express Scripts web site at www.express-scripts.com.

Kentucky Clinic Pharmacy

If you are under the care of a UK Provider, you will be able to obtain both your immediate need (30-day supply) prescriptions AND your chronic need (up to 90-day supply) prescriptions at the Kentucky Clinic Pharmacy, on a walk-up (in person) basis. The web site is: <http://www.hosp.uky.edu/Pharmacy/outpatientpharmacy.html>

Special Procedure for Injectable Medications:

Express Scripts CuraScript Specialty Pharmacy is a pharmacy management program specializing in the provision of high-cost biotech and other injectable drugs used to treat long-term chronic disease states via the CuraScript Pharmacy. The retail pharmacy of the Member's choice will be able to dispense the first injection prescription and then the Member will be required to obtain subsequent doses from CuraScript Specialty Pharmacy. As an alternative pharmacy to CuraScript, the Member may also use the Kentucky Clinic Pharmacy if you are under the care of a UK Provider. These medications include, but are not limited to, Pegasys, PEG-Intron, Avonex, Betaseron, Copaxone, Rebif, Humira, Enbrel, Neupogen, and Lovenox.

There are other medications which include, but are not limited to Lupron Depot, and Thyrogen that are NOT available on a first-dose basis from the retail pharmacy, but may ONLY be obtained from the Kentucky Clinic Pharmacy or Express Scripts CuraScript program.

There are other injectable medications that may be administered only by the physician. Coverage status of these medications as a pharmacy benefit versus medical benefit is subject to review and prior-approval by the Plan.

Covered Prescription Drugs

1. Covered prescription drugs, medicines or medications must
 - a. Be prescribed by a qualified practitioner for the treatment of a sickness or bodily injury;
 - b. Be dispensed by a pharmacist;
 - c. Require a prescription by federal law unless otherwise excluded.

Covered Prescription Drugs (continued)

2. Benefits are provided for Medically Necessary Prescription Drugs and medicines incidental to care of an Outpatient.
3. All compound medications containing at least one prescription ingredient in a therapeutic amount.
4. Injectable insulin when prescribed by a physician, including diabetic supplies (needles, syringes, test strips, lancets, pens).
5. Aerochambers, spacers, peak flow meters;
6. Self-administered injectable drugs, limited to those approved by the Prescription Benefit, and available through the Participating Pharmacies or Express Scripts Curascript program;
7. Selected high-cost Injectable drugs intended for administration in a Provider's office may be covered ONLY if pre-approved by the Plan and obtained ONLY through the Kentucky Clinic Pharmacy or Express Scripts Curascript Pharmacy program.
8. Oral contraceptives;
9. Special Foods for Inborn Errors of Metabolism: Amino acid modified preparations and low-protein modified food products for the treatment of inherited metabolic diseases if the amino acid products are prescribed for the therapeutic treatment of inherited metabolic diseases and administered under the direction of a physician.
 - a. Coverage for amino acid modified preparations and infant formulas are subject, for each Plan Year, to a cap of twenty-five thousand dollars (\$25,000), and low-protein modified food products shall be subject, for each Plan Year, to a cap of four thousand (\$4,000), subject to annual inflation adjustments.
 - b. Covered services under this section are for the following conditions: (1) Phenylketonuria; (2) Hyperphenylalaninemia; (3) Tyrosinemia (types I, II and III); (4) Maple syrup urine disease; (5) A-ketoacid dehydrogenase deficiency; (6) Isovaleryl-CoA dehydrogenase deficiency; (7) 3-methylcrotonyl-CoA carboxylase deficiency; (8) 3-methylglutaconyl-CoA hydratase deficiency; (9) 3-hydroxy-3-methylglutaryl-CoA lyase deficiency (HMG-CoA lyase deficiency); (10) b-ketothiolase deficiency; (11) Homocystinuria; (12) Glutaric aciduria (types I and II); (13) Lysinuric protein intolerance; (14) Non-ketotic hyperglycinemia; (15) Propionic acidemia; (16) Gyrate atrophy; (17) Hyperornithinemia / hyperammonemia / homocitrullinuria syndrome; (18) Carbamoyl phosphate synthetase deficiency; (19) Ornithine carbamoyl transferase deficiency; (20) Citrullinemia; (21) Arginosuccinic aciduria; (22) Methylmalonic acidemia; and (23) Argininemia.
 - c. The Member should use Participating Pharmacies for prescription products and special supplements. If the purchase of such foods is from a supplier who will not bill Express Scripts, the Member should submit the detailed receipt along with a copy of the prescription to University of Kentucky Employee Benefits Customer Service for reimbursement.

LIMITS TO COVERED PRESCRIPTION DRUG BENEFIT

1. The covered benefit for any one prescription will be limited to:
 - a. Quantities that can reasonably be expected to be consumed or used within 30 days or as otherwise authorized by the Plan;
 - b. Refills only up to the number specified by a physician;
 - c. Refills up to one year from the date of the initial prescription order.
2. Certain prescription drugs require prior-authorization in accordance to guidelines adopted by Express Scripts, including but not limited to: growth hormones, Epogen/Procrit, Enbrel, Humira, Prolastin, Lidoderm, Lovaza, Forteo, Regranex, and Aranesp. .
3. Inclusion of a particular medication on the Preferred Drug List is not a guarantee of coverage. The level of benefits received is based on your prescription drug benefit and the Preferred Drug List status of each drug at the time the prescription is filled. The Plan reserves the right to reassign drugs to a different level or non-formulary status at any time during the plan year. The Plan also reserves the right to change quantity limits or prior authorization status during the plan year.
4. Certain medical supplies and drugs may be separate from the Prescription Drug Benefit. Members may not obtain these items as pharmacy benefits using the Plan's prescription benefit. The supplier of these items must submit a claim directly to the member's UK health plan.

EXCLUDED PRESCRIPTION DRUGS

1. Over the counter products that may be purchased without a written prescription or their equivalents. This includes those drugs or medicines which become available without a prescription having previously required a prescription. This does not apply to injectable insulin, insulin syringes and needles and diabetic supplies, which are specifically included.
2. Over the Counter equivalents: As determined by the Prescription Benefit, these are selected prescription drugs (legend drugs) according to First DataBank (FDB) with OTC equivalent product(s) available.
 - a. These products have a similar OTC product which has an identical strength, an identical route of administration, identical active chemical ingredient(s), and an identical dosage form (exceptions may be made for similar oral liquid dosage forms); (e.g., Niferex-150, Lac-Hydrin, benzoyl peroxide products, Lamisil AT, Lotrimin AF).
 - b. These products have a similar OTC product which has an identical systemic strength (for orally administered medications; or can achieve an identical systemic strength by using multiples of the OTC product [reserved for select products]), same route of administration, same active chemical ingredient (variations of salt forms included), and a similar dosage form. Topically administered legend products may not have the same strength (concentration) as their similar OTC equivalent, but will reside within or near a range of strengths available (lower strength legend products will be included if there are higher strength OTC products available) for similar OTC equivalent products (e.g., benzoyl peroxide products, lidocaine products).

EXCLUDED PRESCRIPTION DRUGS (continued)

3. Therapeutic devices or appliances, even though such devices may require a prescription including (but not limited to):
 - a. Hypodermic needles, syringes, (except needles and syringes for diabetes);
 - b. Support garments;
 - c. Test reagents;
 - d. Mechanical pumps for delivery of medications and ancillary pump products;
 - e. Implantable insulin pumps;
 - f. Other non medical substances;
 - g. Durable medical equipment
4. Injectable drugs, including but not limited to:
 - a. Immunization agents;
 - b. Biological serum; Vaccines;
 - c. Blood or blood plasma; or
 - d. Self administered medications not indicated in covered prescription drugs.
 - e. Injectable drugs intended for administration in a Provider's office or other medical facilities are NOT covered if purchased by a Member directly from a retail pharmacy.
5. Any oral drug or medicine or medication that is consumed or injected, at the place where the prescription is given, or dispensed by the qualified practitioner;
6. Contraceptives, other than oral, topical patch, Nuvaring, or Medroxyprogesterone injection, whether medication or device, regardless of the purpose for which they are prescribed (e.g., diaphragms, IUDs);
7. Implantable time-released medications or drug delivery implants.
8. Abortifacients (drugs used to induce abortions - refer to medical benefit for life threatening abortion coverage);
9. Experimental or investigational drugs or drugs prescribed for experimental, non-FDA approved, indications.
10. Any drug prescribed for intended use other than for:
 - Indications approved by the FDA; or
 - Recognized off-label indications through peer-reviewed medical literature;
11. Compound chemical ingredients or combination of federal legend drugs in a non-FDA approved dosage form. Drugs, including compounded drugs, which are not FDA approved for treatment for a specified category of medical conditions, unless the Plan determines such use is consistent with standard medical practice and has been effective in published peer review medical literature as to leading to improvement in health outcomes.
12. Dietary supplements, nutritional products, or nutritional supplements except for hereditary metabolic diseases only;
13. Herbs, minerals, fluoride supplements and vitamins, except prenatal (including greater than one milligram of folic acid) and pediatric multi-vitamins with fluoride;
14. Progesterone crystals or powder in any compounded dosage form;

EXCLUDED PRESCRIPTION DRUGS (continued)

15. Allergen extracts;
16. Anabolic steroids;
17. Treatment for onychomycosis (nail fungus), except for immunocompromised or diabetic patients;
18. Medications used in the treatment of a non-covered diagnosis.
19. Any drug used for infertility purposes, including but not limited to oral, vaginal or injectable (e.g., Clomid, Crinone, Profasi, and HCG).
20. Any drug used for cosmetic purposes, including but not limited to:
 - Tretinoin (e.g., Retin A), except if you are under age 30 or are diagnosed as having adult acne;
 - Anti wrinkle agents or photo-aged skin products (e.g., Renova, Avage);
 - Dermatological or hair growth stimulants (e.g., Propecia, Vaniqa);
 - Pigmenting or de-pigmenting agents (e.g., Solaquin);
 - Injectable cosmetics (e.g., Botox)
21. Anorectic or any drug used for the purpose of weight reduction or weight control, suppress appetite or control fat absorption, including, but not limited to, Adderall, Dexedrine, Xenical.
22. Any drug prescribed for impotence and or sexual dysfunction, (e.g., Muse, Viagra, Cialis, Levitra, Caverject, Edex, Yohimbine).
23. Any service, supply or therapy to eliminate or reduce a dependency on or addiction to tobacco and tobacco products, including but not limited to nicotine withdrawal therapies or smoking cessation medications (NOTE: Chantix [varenicline] coverage is limited to \$500 per member per year; coverage also is provided for bupropion SR).
24. For prescription drugs:
 - In a quantity which is in excess of a 30 day supply obtained at a retail pharmacy;
 - In a quantity which is in excess of a 90 day mail order supply;
 - In a quantity which is in excess of the amount prescribed;
25. Replacement of lost or stolen medications is not covered.
26. Drugs obtained at a non-participating provider pharmacy.
27. Any drug for which a charge is customarily not made, or for which the dispenser's charge is less than the co-payment amount in the absence of this benefit.
28. Prescriptions that are to be taken by or administered to the covered person, in whole or in part, while he or she is a Member in a facility where drugs are ordinarily provided by the facility on an inpatient basis, are not covered. Inpatient facilities include, but are not limited to:
 - Hospital;
 - Rest home;
 - Sanitarium;
 - Skilled nursing facility;
 - Convalescent hospital;
 - Hospice facility

EXCLUDED PRESCRIPTION DRUGS (continued)

Benefits are not provided for medication used by an Outpatient to maintain drug addiction or drug dependency, Methadone Maintenance Program or medications which are excessive or abusive for your condition or diagnosis.

The Plan Manager may decline coverage of a specific medication or, if applicable, drug list inclusion of any and all drugs, medicines or medications until the conclusion of a review period not to exceed six (6) months following FDA approval for the use and release of the drug, medicine or medication into the market.

Items that may be covered by state or federal programs, such as items covered by Worker's Compensation.

Expense incurred will not be payable for the following:

- Legend drugs which are not recommended and not deemed necessary by a prescriber;
 - The administration of covered medication;
 - Any drug, medicine or medication received by the covered person:
 - Before becoming covered under the Plan; or
 - After the date the covered person's coverage under the Plan has ended;
 - Any drug, medicine or medication labeled "Caution - limited by Federal Law to investigational use" or any experimental drug, medicine or medication, even though a charge is made to the covered person;
 - Any costs related to the mailing, sending or delivery of prescription drugs;
 - Any fraudulent misuse of this benefit including prescriptions purchased for consumption by someone other than the covered person;
 - Prescription or refill for drugs, medicines or medications that are lost, stolen, spilled, spoiled or damaged;
 - More than one prescription for the same drug or therapeutic equivalent medication prescribed by one or more Qualified Practitioners and dispensed by one or more Pharmacies until at least 75% of the previous Prescription has been used by the Covered Person, unless the drug or therapeutic equivalent medication is dispensed at a mail order service in which case 66% of the previous Prescription must have been used by the covered person;
 - Any drug or biological that has received an "orphan drug" designation, unless approved by the Plan;
- Any Co-payment or Coinsurance you paid for a prescription that has been filled, regardless of whether the Prescription is revoked or changed due to adverse reaction or change in dosage or Prescription

UK PRESCRIPTION PLAN COMPLAINT AND GRIEVANCE PROCESS

There is a formal complaint and appeal process for handling Member concerns. A complaint is an oral or written expression of dissatisfaction. An appeal is a request to change a previous decision made by Express-Scripts for the Prescription Benefit. If a Covered Person has a problem or complaint regarding any aspect of the administration of benefits by UK Prescription Plan, the Member may contact the UK HR Benefits Office or Express Scripts Customer Service to discuss the matter. If the matter cannot be resolved within a reasonable time to the Member's satisfaction, the Member may submit a written appeal. The UK Prescription plan provides a five-step appeal process to resolve Member concerns. The administrative remedies established by this appeal process must be satisfied before legal remedies are sought.

Step 1 - Informal Inquiry

We recommend that you always contact Express Scripts Customer Service first when you have a problem, concern or complaint. The Customer Service toll-free number is 1-877-242-1864 (or 1-800-972-4348 for hearing-impaired). You may also write UK HR Prescription Benefits, 115 Scovell Hall, Lexington, KY 40506-0064 or call the Benefits Office at 1-800-999-2183, option 3.

Inquiries should include a summary of the issue, provide a description of any previous contact(s) with the Plan regarding the matter in question, and describe the relief sought. Most inquiries are handled immediately. If further research is required, a representative will respond to you within 7 working days. If additional information from a Provider/Prescriber is required, the Plan may need additional time to respond to your concern through all phases of the appeal process. In such cases, the Plan will notify you of any delays.

Step 2 - Written Appeal

If your concern is not settled to your satisfaction at Step 1, you may appeal the decision within 45 days following the day of your first request for coverage by submitting a written statement of concern to:

Express Scripts, Inc.
Attention: Pharmacy Appeals – DIV KYU
6625 West 78th Street
Mail Route #BL0390
Bloomington, MN 55439

The statement should include a summary of the complaint or issue, information regarding previous contact(s) with the plan regarding the matter in question and a description of the relief sought. Express Scripts Appeals Dept. will notify you of the decision within 30 days after receipt of the appeal.

Step 3 - Formal Grievance Hearing

If you are not satisfied with the outcome of your appeal, you may submit a written request for a hearing to the Prescription Plan Grievance Committee within 30 days after receipt of the appeal decision. The request should be directed to UK HR Benefits, Prescription Plan Appeals Coordinator, 115 Scovell Hall, Lexington, KY 40506-0064-. The Grievance Committee will acknowledge your request within 7 working days and hear your case within 30 days. The Grievance Committee will review the appeal decision, and any additional evidence you submit, and make a recommendation. If the Grievance Committee recommends that the relief you sought be granted, you will be promptly informed. If the Grievance Committee recommends that the denial be upheld, you will be notified within 60 days.

Step 4 - Final Internal Appeal

If you are not satisfied with the outcome of the Grievance Hearing, you may submit a written request within 30 days to the Associate Vice President, Human Resource Services, at the University of Kentucky, 101 Scovell Hall, Lexington, KY 40506-0064. The statement should include a summary of the complaint or issue, information regarding previous contact(s) with the plan regarding the matter in question and a description of the relief sought. The UK Director of Employee Benefits has the discretion to establish a committee to perform the Final Appeal process. The Director and/or the committee so established, as applicable, shall review the entire grievance file, including prior decisions rendered on the matter under review, and may request additional information from the participants, prior to rendering the final appeal decision. The final appeal decision will be rendered within 30 days of request.

External Grievance Process

- (A) If a Participant has exhausted the Plan's internal appeals process and the Participant is not satisfied or the Plan failed to render a decision within the specific timeframe, a Participant may be eligible for an External Review by an Independent Review Entity under the following conditions:
- (1) The Plan made an adverse determination, as defined in KRS 304.17A-600 (1) (a); Definitions for KRS 304.17A-600 to 304.17A-633:
 - (a) "Adverse determination" means a determination by an insurer or its designee that the health care services furnished or proposed to be furnished to a covered person are:
 - i. Not medically necessary, as determined by the insurer, or its designee or experimental or investigational, as determined by the insurer, or its designee; and
 - ii. Benefit coverage is therefore denied, reduced, or terminated.
 - (b) "Adverse determination" does not mean a determination by an insurer or its designee that the health care services furnished or proposed to be furnished to a covered person are specifically limited or excluded in the covered person's health benefit plan;
 - (2) The Participant was enrolled on the date of the service, or, if prospective denial, was enrolled and eligible to receive covered benefits on the date the service was requested; and
 - (3) The entire cost of treatment or service will cost the Participant at least \$100 if not covered by the Plan.

- (B) A Participant, an authorized person or a Provider with the Participant's consent may request an External Review. The request for review must be received within 60 days after the Plan's internal appeal decision letter. The confidentiality of all records used in the review shall be maintained throughout the process. A Participant shall make a request for External Review in writing to the Plan. The written consent authorizing the Independent Review Entity to obtain all necessary medical records from both the Plan and the Provider with information related to the denied coverage shall accompany the request. The Plan shall have consent forms available to Participants upon request to a toll-free telephone number or at an address noted in the Certificate of Coverage.
- (C) The External Review decision shall be rendered by the Independent Review Organization within 21 days after receipt of the request by the Plan. An extension of up to 14 days is permitted if agreed to by both the Participant and the Plan. A participant may request that an appeal be expedited if the Participant is hospitalized or if the normal 21 day timeframe would place the Participant's life at risk. If expedited, the decision shall be made within 24 hours. An extension of up to 24 hours is permitted if the Participant and the Plan agree. If the decision of the Independent Review Organization is in favor of the Participant, the Plan must comply with the decision.
- (D) A Participant requesting External Review shall be assessed a \$25 filing fee that is to be paid to the Independent Review Entity and shall be refunded to the Participant if the final decision is in favor of the Participant. If a Participant is unable to pay the filing fee, the Participant shall request a waiver of the filing fee in writing to the Plan. The cost of External Review shall be paid by the Plan. If the Plan decides that a Participant is not eligible for an External Review and the Participant disagrees, the Participant may file a complaint with the Kentucky Department of Insurance. The Department of Insurance will render a decision within five days. A Participant with questions about the External Review process may contact the Appeals Department of the Provider or the Plan.

CONTACT INFORMATION

If you have questions about the retail drug program, the mail order program or your prescription order, please call the Express-Scripts toll free customer service number at 1-877-242-1864 (or 1-800-899-2114 for hearing impaired). These toll-free numbers are listed on the back of your pharmacy benefit member identification card.

You may also obtain information by calling University of Kentucky Employee Benefits Customer Service, or by going to the web site address: <http://www.uky.edu/HR/benefits> or http://www.uky.edu/HR/benefits/prescription_overview.html and click on the available links to access the type of information you need. You may also contact the UK Prescription Benefit Pharmacists in the UK Employee Benefits Office.

TERMINATION OF COVERAGE

Coverage under this plan will terminate on the date a participant is no longer enrolled in a covered University of Kentucky Health Plans (UK-HMO, UK-PPO, , UK-EPO, UK-RHP, or UK-Indemnity).

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Autism Addendum to UK-HMO COC - Page 73

UK-HMO LSA – Addendum to Certificate of Coverage – 2011-2012

Autism Services

Autism Services Limit – Medical Services

Age 1 – 6	\$50,000 per covered person per calendar year
Age 7 – 21	\$1,000 monthly benefit(s) per covered person
Therapy services for autism are first payable under the specific therapy benefit and once those limits are exhausted, services are covered under the autism benefit. <i>Therapy co-payments continue to be applied to these additional therapy services provided.</i>	

Treatment for autism spectrum disorders includes the following care:

- a. Medical care;
- b. Habilitative or rehabilitative care;
- c. Pharmacy care, covered under the UK Pharmacy Benefit
- d. Psychiatric care;
- e. Psychological care;
- f. Therapeutic care; and
- g. Applied behavior analysis prescribed and ordered by a licensed health or allied health professional.

Physical Therapy (PT); Occupational Therapy (OT); and Speech Therapy (ST) limits: PT, OT, and ST visits are limited to 45 visits per year combined with all other therapy services (except ABA). The first 45 therapy visits will not be taken out of the autism benefit. Any PT, OT, or ST after the initial 45 visits will be applied to the autism benefit. Therapy co-payments will continue to be applied to the services exceeding the 45 visit limit and taken out of the autism benefit.

Applied Behavioral Analysis (ABA): ABA means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. The ABA service payments will be applied to the autism benefit. These services must be performed by provider who is certified in Applied Behavioral Analysis. There are no visit limits for ABA services but these services will have a therapy co-payment applied. ABA services will be limited by medical necessity as well as the maximum autism service limits above.

Respite care services: Respite care will be reimbursed to a maximum of \$375 per month unless the patient is enrolled in a certified ABA program. If the patient is receiving services from a certified ABS

provider, no respite services will be available for this member. **Benefits are subject to a 50% co-payment per service.**

ABA Medical Necessity Authorizations: Applied Behavioral Analysis services for autism are subject to medical necessity reviews at least one time a year, unless the insurer and the individual's provider agree that a more frequent review is necessary.

Upon request of the reimbursing insurer, an autism services provider shall furnish medical records, clinical notes, or other necessary data that substantiate that initial or continued treatment or services that are medically necessary and are resulting in improved clinical status.

When treatment is anticipated to require continued services to achieve demonstrable progress, the insurer may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, anticipated outcomes stated as goals, and the frequency by which the treatment plan will be updated.

The treatment plan shall contain specific cognitive, social, communicative, self-care, or behavioral goals that are clearly defined, directly observed, and continually measured and that address the characteristics of the autism spectrum disorder.



State-of-the-art UK Chandler Emergency Department, opened Summer 2010

UK-HMO is a benefit structure and provider network available to University of Kentucky employees and their family members through the University's self-insured program. As a self-insured product, it is not a licensed HMO.

For more information, please call toll free
1-800-955-8547.

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