UNIVERSITY OF LOUISVILLE®

2016 Benefits

UNIVERSITY OF LOUISVILLE

2016 Health Plans

	Cardinal Care – Closed to new enrollees		EPO		PPO		PCA HIGH		PCA LOW	
TYPE OF SERVICE	**Network Limited to UofL Physicians, KentuckyOne Providers (that are also in the Anthem Blue Access PPO Network) & Kosair Children's Hospital**	**Out-of-network (Limited ONLY to Anthem Blue Access PPO Network)**	**Network** (Anthem Blue Access PPO Network)	**Out-of-network**	**Network** (Anthem Blue Access PPO Network)	**Out-of-network**	**Network** (Anthem Blue Access PPO Network)	**Out-of-network**	**Network** (Anthem Blue Access PPO Network)	**Out-of-network**
Annual Allowance	Does not apply	Does not apply	Does not apply	Does not apply	Does not apply	Does not apply	$500 Individual $1,000 Employee+ Spouse $2,000 Employee+ Child(ren) $2,000 Family	Does not apply	$500 Individual $1,000 Employee+ Spouse $2,000 Employee+ Child(ren) $2,000 Family	Does not apply
Annual Deductible	None	None	None	None	$250 per person	$500 per person	$1,000 per person	$2,000 per person	$2,000 per person	$4,000 per person
	None	None	None		$750 per family	$1,500 per family	$3,000 per family	$6,000 per family	$4,000 per family	$8,000 per family
Annual Medical Out-of-pocket Maximum (Copays and deductibles accumulate toward the out-of-pocket maximum)	$2,000 per person	$4,000 per person	$2,000 per person	N / A	$2,250 per person	$4,500 per person	$4,000 per person	$8,000 per person	$5,000 per person	$10,000 per person
	$4,000 per family	$8,000 per family	$4,000 per family		$4,750 per family	$13,500 per family	$9,000 per family	$18,000 per family	$10,000 per family	$20,000 per family
Physician office (OBGYN visits covered as Primary Care) PCP= Primary Care Physician	$0 PCP	Plan pays 60%	$20 PCP; $0 PCP UofL Physicians	Not Covered	$15 PCP; $0 PCP UofL Physicians	60% after deductible	90% after deductible; UofL PCP will apply a $20 discount off the normal network discount	60% after deductible	80% after deductible; UofL PCP will apply a $20 discount off the normal network discount	50% after deductible
	$35 Specialist, UofL Physicians		$35 Specialist	Not Covered	$30 Specialist					
Preventive Care										
Routine physicals, Well-child check-ups and routine immunizations	100%	Plan pays 60%	100%	Not Covered	100%	60% after deductible	100%	60% after deductible	100%	50% after deductible
Mammography screenings Routine GYN exams	100%	Plan pays 60%	100%	Not Covered	100%	60% after deductible	100%	60% after deductible	100%	50% after deductible
Lab, X-ray or other preventive tests	100%	Plan pays 60%	100%	Not Covered	100%	60% after deductible	100%	60% after deductible	100%	50% after deductible
Inpatient Hospital										
Inpatient care	100% after $500 copay per admission	Plan pays 60%	Plan pays 90%	Not Covered	90% after deductible	60% after deductible	90% after deductible	60% after deductible	80% after deductible	50% after deductible
Physician Inpatient care	100%	Plan pays 60%	Plan pays 90%	Not Covered	90% after deductible	60% after deductible	90% after deductible	60% after deductible	80% after deductible	50% after deductible

TYPE OF SERVICE	Cardinal Care		EPO		PPO		PCA High		PCA Low	
Outpatient	**Network**	**Out-of-network**	**Network**	**Out-of-network**	**Network**	**Out-of-network**	**Network**	**Out-of-network**	**Network**	**Out-of-network**
Outpatient surgery - facility	Plan pays 100%	Plan pays 60%	100% after $100 copay	Not Covered	90% after deductible	60% after deductible	90% after deductible	60% after deductible	80% after deductible	50% after deductible
Physician Outpatient services **(other than office visit)**	100%	Plan pays 60%	90%	Not Covered	100% after copays ULP $0 copay Anthem Network $15 copay $30 Specialist	60% after deductible	90% after deductible	60% after deductible	80% after deductible	50% after deductible
Lab Services	100%	100%	100%	Not Covered	100%	60% after deductible	100%	60% after deductible	100%	50% after deductible
X-Ray and Major Diagnostics	100%	Plan pays 60%	Plan pays 90%	Not Covered	90% after deductible	60% after deductible	100%	60% after deductible	100%	50% after deductible
Emergency Room										
	100% after $75 copay	100% after $75 copay	100% after $100 copay	100% after $100 copay	100% after $100 copay	60% after deductible	90% after deductible	90% after deductible. 60% non-emergency	80% after deductible	80% after deductible. 60% non-emergency
Mental Health & Substance Abuse										
Inpatient care	100% after $500 copay per inpatient stay	60% after $500 copay per inpatient stay	Plan pays 90%	Not Covered	90% after deductible	60% after deductible	90% after deductible	60% after deductible	80% after deductible	50% after deductible
Outpatient care - per visit	$0 copay	100%	$20 copay or $0 copay if UofL Physician	Not Covered	$15 copay or $0 copay if UofL Physician	60% after deductible	90% after deductible	60% after deductible	80% after deductible	50% after deductible
Vision										
Vision Exam (one routine exam per year)	100% after $35 copay	100% after $35 copay	100% after $20 copay	Not Covered	100% after copays ULP $0 copay Anthem Network $15 copay $30 Specialist	60%	90% after deductible	60% after deductible	80% after deductible	50% after deductible
Prescription Drugs	**Cardinal Care**		**EPO**		**PPO**		**PCA HIGH**		**PCA LOW**	
Retail										
Prescription Drug Generic Retail	Generic Retail - $5.00		Generic Retail - $8.00		Generic Retail - $8.00		Generic Retail - $8.00		Generic Retail - $8.00	
Prescription Drug Brand Formulary Retail	Brand Formulary Retail - You Pay 20%, up to $50 maximum		Brand Formulary Retail - You Pay 25%, up to $60 maximum		Brand Formulary Retail - You Pay 25%, up to $60 maximum		Brand Formulary Retail - You Pay 25%, up to $60 maximum		Brand Formulary Retail - You Pay 25%, up to $60 maximum	
Prescription Drug Non Formulary Retail	Non-Formulary Retail - You pay 40%, up to $100 maximum		Non- Formulary Retail - You Pay 40%, up to $100 maximum		Non- Formulary Retail - You Pay 40%, up to $100 maximum		Non- Formulary Retail - You Pay 40%, up to $100 maximum		Non- Formulary Retail - You Pay 40%, up to $100 maximum	
Mail Order (90 day supply)										
Prescription Drug Generic Mail Order	Generic Mail Order - $7.50		Generic Mail Order - $16.00		Generic Mail Order - $16.00		Generic Mail Order - $16.00		Generic Mail Order - $16.00	
Prescription Drug Brand Formulary Mail Order	Brand Formulary Mail Order - You Pay 20%, up to $75 maximum		Brand Formulary Mail Order - You Pay 15%, up to $120 maximum		Brand Formulary Mail Order - You Pay 15%, up to $120 maximum		Brand Formulary Mail Order - You Pay 15%, up to $120 maximum		Brand Formulary Mail Order - You Pay 15%, up to $120 maximum	
Prescription Drug Non-Formulary Mail Order	Non-Formulary Mail Order - You Pay 35%, up to $200 maximum		Non-Formulary Mail Order - You Pay 35%, up to $200 maximum		Non-Formulary Mail Order - You Pay 35%, up to $200 maximum		Non-Formulary Mail Order - You Pay 35%, up to $200 maximum		Non-Formulary Mail Order - You Pay 35%, up to $200 maximum	
Brand with Generic Available										
Prescription Drug Brand for which a Generic equivalent is available - retail or mail order	Plan Pays Cost of Generic Drug- You Pay remainder, no maximum		Plan Pays Cost of Generic Drug- You Pay remainder, no maximum		Plan Pays Cost of Generic Drug- You Pay remainder, no maximum		Plan Pays Cost of Generic Drug- You Pay remainder, no maximum		Plan Pays Cost of Generic Drug- You Pay remainder, no maximum	
Annual Prescription Out-of-pocket Maximum	$4,350 per person / $8,450 per family	N / A	$4,600 per person / $9,200 per family	N / A	$4,600 per person / $9,200 per family	N / A	$2,600 per person / $4,200 per family	N / A	$1,600 per person / $3,200 per family	N / A

University of Louisville 2016 Health Plan Rates

Monthly Rates

FT Active With GHN Discount	Cardinal Care	EPO	PPO	PCA High	PCA Low
Employee Coverage	$ 155.00	$ 96.12	$ 78.58	$ 27.12	$ 25.00
Employee + Spouse/QA	$ 355.00	$ 455.04	$ 416.46	$ 303.24	$ 171.64
Employee + Children	$ 222.00	$ 228.21	$ 196.63	$ 104.01	$ 25.00
Employee + Family	$ 380.00	$ 513.24	$ 460.62	$ 306.24	$ 126.78
Two Employee Family (Rate Per EE)	$ 150.00	$ 95.52	$ 69.21	$ 12.50	$ 12.50

FT Active Without GHN	Cardinal Care	EPO	PPO	PCA High	PCA Low
Employee Coverage	$ 195.00	$ 136.12	$ 118.58	$ 67.12	$ 65.00
Employee + Spouse/QA	$ 395.00	$ 495.04	$ 456.46	$ 343.24	$ 211.64
Employee + Children	$ 262.00	$ 268.21	$ 236.63	$ 144.01	$ 65.00
Employee + Family	$ 420.00	$ 553.24	$ 500.62	$ 346.24	$ 166.78
Two Employee Family (Rate Per EE)	$ 190.00	$ 135.52	$ 109.21	$ 52.50	$ 52.50

PT Active and Retirees With GHN Discount	Cardinal Care	EPO	PPO	PCA High	PCA Low
Employee Coverage	$ 407.15	$ 313.24	$ 294.96	$ 241.18	$ 207.74
Employee + Spouse/QA	$ 830.73	$ 810.91	$ 770.70	$ 652.39	$ 515.33
Employee + Children	$ 656.37	$ 591.43	$ 558.52	$ 461.73	$ 363.93
Employee + Family	$ 1,058.95	$ 1,052.16	$ 997.32	$ 836.00	$ 649.10

PT Active and Retirees Without GHN Discount	Cardinal Care	EPO	PPO	PCA High	PCA Low
Employee Coverage	$ 447.15	$ 353.24	$ 334.96	$ 281.18	$ 247.74
Employee + Spouse/QA	$ 870.73	$ 850.91	$ 810.70	$ 692.39	$ 555.33
Employee + Children	$ 696.37	$ 631.43	$ 598.52	$ 501.73	$ 403.93
Employee + Family	$ 1,098.95	$ 1,092.16	$ 1,037.32	$ 876.00	$ 689.10

10-Month FT Active Employee

FT Active With GHN Discount	Cardinal Care	EPO	PPO	PCA High	PCA Low
Employee Coverage	$ 186.00	$ 115.34	$ 94.30	$ 32.54	$ 30.00
Employee + Spouse/QA	$ 426.00	$ 546.05	$ 499.75	$ 363.89	$ 205.97
Employee + Children	$ 266.40	$ 273.85	$ 235.96	$ 124.81	$ 30.00
Employee + Family	$ 456.00	$ 615.89	$ 552.74	$ 367.49	$ 152.14
Two Employee Family (Rate Per EE	$ 180.00	$ 114.62	$ 83.05	$ 15.00	$ 15.00

FT Active Without GHN	Cardinal Care	EPO	PPO	PCA High	PCA Low
Employee Coverage	$ 234.00	$ 163.34	$ 142.30	$ 80.54	$ 78.00
Employee + Spouse/QA	$ 474.00	$ 594.05	$ 547.75	$ 411.89	$ 253.97
Employee + Children	$ 314.40	$ 321.85	$ 283.96	$ 172.81	$ 78.00
Employee + Family	$ 504.00	$ 663.89	$ 600.74	$ 415.49	$ 200.14
Two Employee Family (Rate Per EE	$ 228.00	$ 162.62	$ 131.05	$ 63.00	$ 63.00

10 Month PT Active Employees

PT Active With GHN Discount	Cardinal Care	EPO	PPO	PCA High	PCA Low
Employee Coverage	$ 488.58	$ 375.89	$ 353.95	$ 289.42	$ 249.29
Employee + Spouse/QA	$ 996.44	$ 973.09	$ 924.84	$ 782.87	$ 618.40
Employee + Children	$ 787.64	$ 709.72	$ 670.22	$ 554.08	$ 436.72
Employee + Family	$ 1,270.74	$ 1,262.59	$ 1,196.78	$ 1,003.20	$ 778.92

PT Active Without GHN Discount	Cardinal Care	EPO	PPO	PCA High	PCA Low
Employee Coverage	$ 536.58	$ 423.89	$ 401.95	$ 337.42	$ 297.29
Employee + Spouse/QA	$ 1,044.88	$ 1,021.09	$ 972.84	$ 830.87	$ 666.40
Employee + Children	$ 835.64	$ 757.72	$ 718.22	$ 602.08	$ 484.72
Employee + Family	$ 1,318.74	$ 1,310.59	$ 1,244.78	$ 1,051.12	$ 826.92

12 Month Active Employees

Dental Full-time/Part-time	Monthly Premiums
Employee Coverage	$24.65
Employee + Spouse/QA	$49.26
Employee + Children	$58.15
Employee + Family	$89.93

10 Month Active Employees

Dental Full-time/Part-time	Monthly Premiums
Employee Coverage	$29.57
Employee + Spouse/QA	$59.11
Employee + Children	$69.78
Employee + Family	$107.92

12 Month Active Employees

Vision Full-time/Part-time	2014 Monthly Premiums
Employee Coverage	$4.28
Employee + Spouse/QA	$7.76
Employee + Children	$8.23
Employee + Family	$11.81

10 Month Active Employees

Vision Full-time/Part-time	Monthly Premiums
Employee Coverage	$5.14
Employee + Spouse/QA	$9.31
Employee + Children	$9.88
Employee + Family	$14.17

Anthem BlueCross BlueShield

UNIVERSITY OF LOUISVILLE

Your Summary of Benefits

EPO

Anthem Blue Cross and Blue Shield and University of Louisville want to help you take control and make the most of your health care benefits. That's why we provide convenient services to get your health care questions answered quickly and accurately:

- **Anthem.com** – Take advantage of easy, time-saving online tools. You can check your eligibility, benefits, claims, claim payments, search for a doctor, hospital and much more.
- **24/7 NurseLine** – Always there for you. A nurse is a phone call away as well as other health resources, all available 24-hours a day, 7-days a week to provide you with information that can help you make informed decisions. Call toll free at **888.279.5378**.
- **Customer Care** telephone support – Need more help? Contact your designated member services team at **855.747.1137**. Get answers to your benefit questions or receive guidance when looking for a doctor or hospital.

The **Benefit Summary** is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary conflicts in any way with the Summary Plan Description (SPD), the SPD shall prevail. It is recommended that you review your SPD for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

Plan Highlights

Types of Coverage	Network Benefits
Annual Deductible	
Individual Deductible Family Deductible	No deductible No deductible
Out-of-Pocket Maximum (Member copayments (excluding Pharmacy) accumulate toward the OOP maximum)	
Individual Out-of-Pocket Maximum Family Out-of-Pocket Maximum	$2,000 per year $4,000 per year
Benefit Plan Coinsurance (The amount the Plan pays)	
	90% coverage
Lifetime Maximum	
There is no dollar limit to the amount the Plan will pay for essential benefits during the entire period you are enrolled in this Plan.	No lifetime maximum benefit
Prescription Drug Benefits	
Prescription drug benefits are shown under separate cover.	
Information of Precertification	
Precertification is required for certain services. Please refer to your Benefit Plan Document.	
Information on Benefit Limits	
Out-of-pocket maximum and benefit limits are calculated on a calendar year basis. All benefits are reimbursed based on eligible expenses. For a definition of eligible expenses, please refer to your plan SPD. When benefit limits apply, the limit refers to any combination of network and non-network benefits unless specifically stated in the benefit category.	

Benefits

Types of Coverage	Network Benefits
Ambulance Services (Emergency and non-emergency)	
	100% after you pay a $100 copayment per trip
Dental Services (Accident only)	
	90% coverage
Durable Medical Equipment (DME)	
	100% coverage
Emergency Health Services - Outpatient	
	100% after you pay a $100 copayment per visit. If you are admitted as an inpatient to a network hospital directly from the emergency room, you will not have to pay this copayment. The benefits for an inpatient stay in a network hospital will apply instead.
Hearing Aids	
One per year every 36 months	100% coverage
Home Health Care	
Benefits are limited to 100 visits per year	100% coverage
Hospice Care	
	100% coverage
Hospital Inpatient Stay	
	90% coverage
Lab, X-Ray and Major Diagnostics – Outpatient	
Lab X-Ray and Diagnostics	100% coverage 90% coverage
Lab, X-Ray and Major Diagnostics (CT, PET, MRI and Nuclear Medicine)	
Lab X-Ray and Diagnostics	100% coverage 90% coverage
Mental Health Services	
	Inpatient - 90% coverage Outpatient - 100% after you pay a $20 copayment per visit ULP Providers – covered in full
Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders	
	Inpatient - 90% coverage Outpatient - 100% after you pay a $20 copayment per visit ULP Providers – covered in full
Pharmaceutical Products - Outpatient	
This includes medications administered in an outpatient setting, in the physician's office and by a home health agency.	Physician's office – 100% coverage All other place of service – 100% after you pay a $35 copay
Physician Fees for Surgical and Medical Services	
	90% coverage
Physician's Office Services – Sickness and Injury	
Primary Physician	100% - copay waived if ULP Provider $20 Copayment per visit for Anthem PCP
Specialist Physician	100% after you pay a $35 Copayment per visit for Anthem PCP

Types of Coverage	
Pregnancy – Maternity Services	
Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each covered Health Service category in this Benefit Summary.	For services provided in the physician's office, a copayment will only apply to the initial office visit Infertility treatment (Limited to $5,000 per lifetime)
Preventive Care Services (Covered health services include but not limited to:)	
Primary Physician Office Visit	100% coverage
Specialist Physician Office Visit	100% coverage
Lab, X-Ray or other preventive tests	100% coverage
Prosthetic Devices	
	100% coverage
Reconstructive Procedures	
Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
Rehabilitation Services – Outpatient Therapy and Manipulative Treatment	
Benefits are limited as follows: 50 visits combined of physical and occupational therapy 25 visits combined of speech and cognitive therapy 30 visits of manipulative treatment 25 visits combined of respiratory and pulmonary therapy	PT/OT 100% copay waived for ULP Providers $20 Copayment per visit for Anthem PCP Manipulative and all other therapies - 100% after you pay a $35 copayment per visit
Scopic Procedures – Outpatient Diagnostic and Therapeutic	
Diagnostic scopic procedures include, but are not limited to: Colonoscopy; Sigmoidoscopy; Endoscopy. For Preventive Scopic Procedures, refer to the Preventive Care Services category.	90% coverage
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services	
Benefits are limited as follows: 120 days per year	100% coverage
Substance Use Disorder Services	
	Inpatient - 90% coverage Outpatient - 100% after you pay a $20 copayment per visit ULP Providers – covered in full
Surgery – Outpatient	
	$100 coverage after you pay $100 copayment
Transplantation Services	
	90% coverage For network benefits, services must be received at a Blue Distinction Center for Transplant.
Urgent Care Center Services	
	100% coverage after you pay a $35 copayment per visit
Vision Examinations	
Benefits are limited as follows: 1 routine exam every year	100% coverage after you pay a $20 copayment per visit

Medical Notes

- It is recommended that you review your SPD for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.
- In network deductibles and out of pocket amounts apply to the out of network accumulations. However, out of network deductible and out of pocket amounts are not included in the in network accumulations.
- **Dependent Age:** to the end of the calendar year the child attains age 26.
- When choosing a non-network provider, the member is responsible for any balance due after the plan payment.
- **Benefit Period**: Equals calendar year
- **Behavioral Health Services:** Mental Health and Substance Abuse benefits provided in accordance with the Federal Mental Health Parity.
- **Precertification**: Members are encouraged to always obtain prior approval when using non network providers. Precertification will help avoid any unnecessary reduction in benefits for non-covered or non-medically necessary services.
- **Primary Care Physician:** Network Provider who is a practitioner that specializes in family and general practice, internal medicine and pediatrics.
- **Specialist Physician**: Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.
- **Preventive Care Services** that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits are covered.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com or by calling 1-855-747-1137.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0.**	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers
Is there an out–of–pocket limit on my expenses?	Yes. **$2,000** Individual/ **$4,000** Family for Network Providers. Pharmacy Max Out of Pocket; In-Network **$4,600** Individual/ **$9,200** Family. Non-Network; **Unlimited** Individual/Family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, Balance-billed charges and Health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.anthem.com**or call **1-855-747-1137** for a list of Network providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page **Error! Bookmark not defined.** for how this plan pays different kinds of **providers**.
Do I need a referral to	No. You don't need a referral to	You can see the **specialist** you choose without permission from this plan.

see a specialist?	see a specialist.	
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **Coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use Network **providers** by charging you lower **deductibles**, **copayments** and **Coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	U of L Physician - 100% Coverage; Anthem Blue Access PPO Network $20 Copay/Visit	Not Covered	————————none————————
	Specialist visit	**$35** Copay/Visit	Not Covered	————————none————————
	Other practitioner office visit	**$35** Copay/Visit for Manipulative Treatment	Not Covered	Coverage is limited to 30 visits for Manipulative treatment. Acupuncture is Not Covered.
	Preventive care/screening/immunization	100% Coverage	Not Covered	————————none————————

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have a test	Diagnostic test (lab, blood work)	**100%** coverage	Not Covered	Failure to obtain pre-authorization may result in non-coverage or reduced benefit for below services. Diagnosis of Sleep Disorders, Gene Expression Profiling for Managing Breast Cancer Treatment and Genetic Testing for Cancer Susceptibility.
	Imaging (X-ray, CT/PET scans, MRIs)	**10%** Coinsurance	Not Covered	Failure to obtain pre-authorization may result in non-coverage or reduced benefit for below service. MRI Guided High Intensity Focused Ultrasound Ablation of Uterine Fibroids.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.	Typically Generic drugs	**$8** Copayment	**$8** Copayment	
	Typically Preferred brand drugs	**25%** Coinsurance	**25%** Coinsurance	A maximum coinsurance amount of $60 applies to each prescription.
	Typically Non-preferred brand drugs	**40%** Coinsurance	**40%** Coinsurance	A maximum coinsurance amount of $100 applies to each prescription.
	Typically Specialty drugs	Follows above.	Follows above.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**$100** Copay/Surgery	Not Covered	Failure to obtain pre-authorization may result in non-coverage or reduced benefit for below surgery. Gender Reassignment Surgery: Human Organ and Bone Marrow/Stem Cell Transplants. Please call the plan for excluded details.
	Physician/surgeon fees	100% Coverage	Not Covered	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	**$100** Copay/Visit	**$100** Copay/Visit	If admitted, the ER copay is waived. Failure to obtain pre-authorization if require notification no later than 2 business days after admission may result in non-coverage or reduced benefit.
	Emergency medical transportation	**$100** Copay/ Trip	**$100** Copay/ Trip	Failure to obtain pre-authorization may result in non-coverage or reduced benefit for Air Ambulance (excludes 911 initiated emergency transport).
	Urgent care	**$35** Copay/Visit	Not Covered	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	**10%** Coinsurance	Not Covered	Failure to obtain pre-authorization may result in non-coverage or reduced benefit.
	Physician/surgeon fee	**10%** Coinsurance	Not Covered	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	U of L Physician - 100% Coverage; Anthem Blue Access PPO Network $20 Copay/Visit	Not Covered	Failure to obtain pre-authorization may result in non-coverage or reduced benefits for Intensive Outpatient therapy(IOP).
	Mental/Behavioral health inpatient services	**10%** Coinsurance	Not Covered	Failure to obtain pre-authorization may result in non-coverage or reduced benefit.
	Substance abuse disorder outpatient services	U of L Physician - 100% Coverage; Anthem Blue Access PPO Network $20 Copay/Visit	Not Covered	Failure to obtain pre-authorization may result in non-coverage or reduced benefits for Intensive Outpatient therapy(IOP).
	Substance abuse disorder inpatient services	**10%** Coinsurance	Not Covered	Failure to obtain pre-authorization may result in non-coverage or reduced benefit.
If you are pregnant	Prenatal and postnatal care	U of L Physician - 100% Coverage; Anthem Blue Access PPO Network $20 Copay/Visit	Not Covered	In-Network benefit applies for first initial visit only. There may be other levels of cost share that are contingent on how services are provided, please see your formal contract of coverage for a complete explanation.
	Delivery and all inpatient services	**10%** Coinsurance	Not Covered	Applies to Inpatient facility. Other cost shares may apply depending on the service provided. Failure to obtain pre-authorization may result in non-coverage or reduced benefit.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	100% Coverage	Not Covered	Coverage is limited to 100 visits per calendar year.
	Rehabilitation services • Physical Therapy/Occupational Therapy • Pulmonary Therapy/Speech Therapy	U of L Physician - 100% Coverage; Anthem Blue Access PPO Network $20 Copay/Visit **$35** Copay/Visit	Not Covered	Coverage is limited to 50 visits per calendar year combined for Occupational and Physical therapy combined Network and Non-Network. Coverage is limited to 25 visits for each Pulmonary and Speech therapy combined Network and Non-Network. Pre-authorization may be required after the initial twelve (12) visits. Please call the plan for account-specific details.
	Habilitation services	Same as Rehabilitation	Not Covered	All Rehabilitation and Habilitation visits count toward your Rehabilitation visit limit. Pre-authorization may be required after the initial twelve (12) visits. Please call the plan for account-specific details.
	Skilled nursing care	100% Coverage	Not Covered	Coverage is limited to 120 days per calendar year. Failure to obtain pre-authorization may result in non-coverage or reduced benefit.
	Durable medical equipment	100% Coverage	Not Covered	Failure to obtain pre-authorization may result in non-coverage or reduced benefit.
	Hospice service	100% Coverage	Not Covered	——————none——————
If you need dental or eye care	Eye exam	$20 Copay/Visit	Not Covered	1 routine exam every year;
	Glasses	Not Covered	Not Covered	——————none——————
	Dental check-up	Not Covered	Not Covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery (Only for Morbid Obesity)
- Chiropractic care (Manipulative Treatment)
- Infertility treatment (Limited to $5,000 per lifetime)
- Hearing aids
- Routine Eye Care
- Most Coverage provided outside the United States.
  See www.bcbs.com/bluecardworldwide

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-747-1137. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: 1-855-747-1137.

anthem.com

Language Access Services:

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoołwoł íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'ałníhí ya sidáhí bich'į naabídíilkiid. Eí doo biigha daago ni ba'nija'go ho'aałagíí bich'į hodiilní. Hai'dąą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'į hodiilní.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,850
- **Patient pays** $690

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$0
Coinsurance	$520
Limits or exclusions	$170
Total	**$690**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $2,460
- **Patient pays** $2,940

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$0
Coinsurance	$10
Limits or exclusions	$2,930
Total	**$2,940**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **Coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **Coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Anthem BlueCross BlueShield

UNIVERSITY OF LOUISVILLE

Your Summary of Benefits

PPO

Anthem Blue Cross and Blue Shield and University of Louisville want to help you take control and make the most of your health care benefits. That's why we provide convenient services to get your health care questions answered quickly and accurately:

- **Anthem.com** – Take advantage of easy, time-saving online tools. You can check your eligibility, benefits, claims, claim payments, search for a doctor, hospital and much more.
- **24/7 NurseLine** – Always there for you. A nurse is a phone call away as well as other health resources, all available 24-hours a day, 7-days a week to provide you with information that can help you make informed decisions. Call toll free at **888.279.5378**.
- **Customer Care** telephone support – Need more help? Contact your designated member services team at **855.747.1137**. Get answers to your benefit questions or receive guidance when looking for a doctor or hospital.

The **Benefit Summary** is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary conflicts in any way with the Summary Plan Description (SPD), the SPD shall prevail. It is recommended that you review your SPD for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

Plan Highlights

Types of Coverage	Network Benefits	Non-Network Benefits
Annual Deductible (Member copayments do not accumulate towards the deductible)		
Individual Deductible Family Deductible	$250 per year $750 per year	$500 per year $1,500 per year
Out-of-Pocket Maximum (Both deductibles and member copayments (excluding Pharmacy) accumulate towards the OOP maximum)		
Individual Out-of-Pocket Maximum Family Out-of-Pocket Maximum	$2,250 per year $4,750 per year	$4,500 per year $13,500 per year
Benefit Plan Coinsurance (The amount the Plan pays)		
	90% after deductible has been met	60% after deductible has been met
Lifetime Maximum Benefit		
There is no dollar limit to the amount the Plan will pay for essential benefits during the entire period you are enrolled in this Plan.	No lifetime maximum benefit	No lifetime maximum benefit
Prescription Drug Benefits		
Prescription drug benefits are shown under separate cover.		
Information of Precertification		
Precertification is required for certain services. Please refer to your Benefit Plan Document.		
Information on Benefit Limits		
The annual deductible, out-of-pocket maximum and benefit limits are calculated on a calendar year basis. All benefits are reimbursed based on eligible expenses. For a definition of eligible expenses, please refer to your plan SPD. When benefit limits apply, the limit refers to any combination of network and non-network benefits unless specifically stated in the benefit category.		

Benefits

Types of Coverage	Network Benefits	Non-Network Benefits
Ambulance Services (Emergency and non-emergency)		
	100% after you pay a $100 copayment per trip	100% after you pay a $100 copayment per trip Notification required for non-emergency ambulance services
Dental Services (Accident only)		
	90% after deductible has been met	90% after network deductible has been met
Durable Medical Equipment (DME)		
	90% after deductible has been met	60% after deductible has been met
Emergency Health Services - Outpatient		
	100% after you pay a $100 copayment per visit. If you are admitted as an inpatient to a network hospital directly from the emergency room, you will not have to pay this copayment. The benefits for an inpatient stay in a network hospital will apply instead.	100% after you pay a $100 copayment per visit
Hearing Aids		
One per ear every 36 months	90% after deductible has been met	60% after deductible has been met
Home Health Care		
Benefits are limited to 100 visits per year	90% after deductible has been met	60% after deductible has been met
Hospice Care		
	100%	60% after deductible has been met
Hospital Inpatient Stay		
	90% after deductible has been met	60% after deductible has been met
Lab, X-Ray and Major Diagnostics – Outpatient		
Lab X-ray and Diagnostic services	100% 90% after deductible has been met	60% after deductible has been met
Lab, X-Ray and Major Diagnostics (CT, PET, MRI and Nuclear Medicine)		
	90% after deductible has been met	60% after deductible has been met
Mental Health Services		
	Inpatient - 90% after deductible has been met Outpatient- 100% after you pay a $15 copayment per visit ULP Providers – covered in full	60% after deductible has been met
Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders		
	Inpatient - 90% after deductible has been met Outpatient - 100% after you pay a $15 copayment per visit ULP Providers – covered in full	60% after deductible has been met
Pharmaceutical Products - Outpatient		
This includes medications administered in an outpatient setting, in the physician's office and by a home health agency.	90% after deductible has been met	60% after deductible has been met

Types of Coverage	Network Benefits	Non-Network Benefits
Physician Fees for Surgical and Medical Services		
	90% after deductible has been met	60% after deductible has been met
Physician's Office Services – Sickness and Injury		
University of Louisville Primary Care	100% - copay waived	
Primary Physician	100% after you pay a $15 copayment per visit	60% after deductible has been met
Specialist Physician	100% after you pay a $30 Copayment per visit	60% after deductible has been met
Pregnancy – Maternity Services		
Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each covered Health Service category in this Benefit Summary.	For services provided in the physician's office, a copayment will only apply to the initial office visit. Infertility treatment (Limited to $5,000 per lifetime)	Precertification is required if inpatient stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.
Preventive Care Services (Covered health services include but are not limited to:)		
Primary Physician Office Visit	100% - deductible does not apply	60% after deductible has been met
Specialist Physician Office Visit	100% - deductible does not apply	60% after deductible has been met
Lab, X-Ray or other preventive tests	100% - deductible does not apply	60% after deductible has been met
Prosthetic Devices		
	90% after deductible has been met	60% after deductible has been met
Reconstructive Procedures		
Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.		Precertification is required for certain services
Rehabilitation Services – Outpatient Therapy and Manipulative Treatment		
Benefits are limited as follows: 50 visits combined of physical and occupational therapy 25 visits combined of speech and cognitive therapy 30 visits of manipulative treatment 25 visits combined of respiratory and pulmonary therapy	90% after deductible has been met Chiropractic Treatment - 100% after you pay a $30 copayment per visit	60% after deductible has been met
Scopic Procedures – Outpatient Diagnostic and Therapeutic		
Diagnostic scopic procedures include, but are not limited to: Colonoscopy; Sigmoidoscopy; Endoscopy. For Preventive Scopic Procedures, refer to the Preventive Care Services category.	90% after deductible has been met	60% after deductible has been met
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services		
Benefits are limited as follows: 120 days per year	90% after deductible has been met	60% after deductible has been met
Substance Use Disorder Services		
	Inpatient - 90% after deductible has been met Outpatient - 100% after you pay a $30 copayment per visit ULP Providers – covered in full	60% after deductible has been met

Types of Coverage	Network Benefits	Non-Network Benefits
Surgery – Outpatient		
	90% after deductible has been met	60% after deductible has been met
Transplantation Services		
For network benefits, services must be received at a Blue Distinction Center for Transplant.	90% after deductible has been met	60% after deductible has been met Benefits are limited to $35,000 per covered transplant
Urgent Care Center Services		
	100% after you pay a $30 copayment per visit	60% after deductible has been met
Vision Examinations		
Benefits are limited as follows: 1 routine exam every year	100% after you pay a $15 copayment per visit	60% after deductible has been met

Medical Notes

- It is recommended that you review your SPD for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.
- In network deductibles and out of pocket amounts apply to the out of network accumulations. However, out of network deductible and out of pocket amounts are not included in the in network accumulations.
- **Dependent Age:** to the end of the calendar year the child attains age 26.
- When choosing a non-network provider, the member is responsible for any balance due after the plan payment.
- **Benefit Period**: Equals calendar year
- **Behavioral Health Services:** Mental Health and Substance Abuse benefits provided in accordance with the Federal Mental Health Parity.
- **Precertification**: Members are encouraged to always obtain prior approval when using non network providers. Precertification will help avoid any unnecessary reduction in benefits for non-covered or non-medically necessary services.
- **Primary Care Physician:** Network Provider who is a practitioner that specializes in family and general practice, internal medicine and pediatrics.
- **Specialist Physician**: Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.
- **Preventive Care Services** that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits are covered.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com or by calling 1-855-747-1137.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$250** Individual/ **$750** Family for Network providers. **$500** Individual/ **$1,500** Family for Non-Network providers.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible.**
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$2,250** Individual/ **$4,750** Family for Network providers. **$4,500** Individual/ **$13,500** Family for Non-Network providers. Pharmacy Max Out of Pocket; In-Network **$4,600** Individual/ **$9,200** Family. Non-Network; **Unlimited** Individual/Family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, Balance-billed charges and Health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit.**
Is there an overall annual limit on what	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.

the plan pays?		
Does this plan use a network of providers?	Yes.See www.anthem.com or call **1-855-747-1137** for a list of Network providers.	If you use an in-network doctor or other health care **provider,** this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred,**or participating for **providers** in their **network.**See the chart starting on page 2 for how this plan pays different kinds of **providers.**
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 9. See your policy or plan document for additional information about **excluded services.**

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146 Released on April 23, 2013 (corrected)

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** f ıple, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% wou hange if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use Network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	U of L Physician - 100% Coverage; Anthem Blue Access PPO Network $15 Copay/Visit	**40%** Coinsurance	————————none————————
	Specialist visit	**$30** Copay/Visit	**40%** Coinsurance	————————none————————

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Other practitioner office visit	**$30** Copay/Visit for Chiropractic Treatment	**40%** Coinsurance for Chiropractic Treatment	Coverage is limited to 30 visits combined Network and Non-Network providers for Chiropractic Services (Manipulation). Acupuncture is Not Covered.
	Preventive care/screening/immunization	100% Coverage	**40%** Coinsurance	————————none————————
If you have a test	Diagnostic test (x-ray, blood work)	**100%** coverage	**40%** Coinsurance	Failure to obtain pre-authorization may result in non-coverage or reduced benefits for below services. Diagnosis of Sleep Disorders, Gene Expression Profiling for Managing Breast Cancer Treatment and Genetic Testing for Cancer Susceptibility.
	Imaging (CT/PET scans, MRIs)	**10%** Coinsurance	**40%** Coinsurance	Failure to obtain pre-authorization may result in non-coverage or reduced benefits for below service. MRI Guided High Intensity Focused Ultrasound Ablation of Uterine Fibroids.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.[insert].	Typically Generic drugs	**$8** Copayment	**$8** Copayment	
	Typically Preferred brand drugs	**25%** Coinsurance	**25%** Coinsurance	A maximum coinsurance amount of $60 applies to each prescription.
	Typically Non-preferred brand drugs	**40%** Coinsurance	**40%** Coinsurance	A maximum coinsurance amount of $100 applies to each prescription.
	Typically Specialty drugs	Follows above.	Follows above.	

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**10%** Coinsurance	**40%** Coinsurance	Failure to obtain pre-authorization may result in non-coverage or reduced benefits for below surgery. Gender Reassignment Surgery: Human Organ and Bone Marrow/Stem Cell Transplants. Please refer to the benefit plan document for specific details.
	Physician/surgeon fees	**10%** Coinsurance	**40%** Coinsurance	——————none——————
If you need immediate medical attention	Emergency room services	**$100** Copay/Visit	**$100** Copay/Visit	If admitted, the ER copay is waived for Network providers. Failure to obtain pre-authorization if require notification no later than 2 business days after admission may result in non-coverage or reduced benefits.
	Emergency medical transportation	**$100** Copay/Trip	**$100** Copay/Trip	Failure to obtain pre-authorization may result in non-coverage or reduced benefits for Air Ambulance (excludes 911 initiated emergency transport).
	Urgent care	**$30** Copay/Visit	**40%** Coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	**10%** Coinsurance	**40%** Coinsurance	Failure to obtain preauthorization may result in non-coverage or reduced benefits.
	Physician/surgeon fee	**10%** Coinsurance	**40%** Coinsurance	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	U of L Physician - 100% Coverage; Anthem Blue Access PPO Network $15 Copay/Visit	**40%** Coinsurance	Failure to obtain pre-authorization may result in non-coverage or reduced benefits for Intensive Outpatient therapy(IOP).
	Mental/Behavioral health inpatient services	**10%** Coinsurance	**40%** Coinsurance	Failure to obtain preauthorization may result in non-coverage or reduced benefits.
	Substance abuse disorder outpatient services	U of L Physician - 100% Coverage; Anthem Blue Access PPO Network $15 Copay/Visit	**40%** Coinsurance	Failure to obtain pre-authorization may result in non-coverage or reduced benefits for Intensive Outpatient therapy(IOP).
	Substance abuse disorder inpatient services	**10%** Coinsurance	**40%** Coinsurance	Failure to obtain preauthorization may result in non-coverage or reduced benefits.
If you are pregnant	Prenatal and postnatal care	U of L Physician - 100% Coverage; Anthem Blue Access PPO Network $15 Copay/Visit	**40%** Coinsurance	In-Network copay applies for initial office visit only. There may be other levels of cost share that are contingent on how services are provided, please see your formal contract of coverage for a complete explanation.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Delivery and all inpatient services	**10%** Coinsurance	**40%** Coinsurance	Applies to inpatient facility. Other cost shares may apply depending on the services provided. Failure to obtain pre-authorization may result in non-coverage or reduced benefits for OB delivery stays beyond the Federal Mandate minimum LOS (including newborn stays beyond the mother's stay).

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	**10%** Coinsurance	**40%** Coinsurance	Coverage is limited to 100 visits combined Network and Non-Network per calendar year.
	Rehabilitation services	**10%** Coinsurance	**40%** Coinsurance	Coverage is limited to 50 visits combined Network and Non-Network combined for Occupational and Physical Therapy. Coverage is limited to 25 visits combined Network and Non-Network for Speech Therapy. Coverage is limited to 25 visits combined Network and Non-Network for Pulmonary Therapy including Respiratory. Pre-authorization may be required after the initial twelve (12) visits. Please refer to the benefit plan document for specific details.
	Habilitation services	**10%** Coinsurance	**40%** Coinsurance	All Rehabilitation and Habilitation visits count towards your rehabilitation visit limit. Pre-authorization may be required after the initial twelve (12) visits. Please refer to the benefit plan document for specific details.
	Skilled nursing care	**10%** Coinsurance	**40%** Coinsurance	Coverage is limited to 120 days combined Network and Non-Network per calendar year. Failure to obtain preauthorization may result in non-coverage or reduced benefits.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Durable medical equipment	**10%** Coinsurance	**40%** Coinsurance	Failure to obtain preauthorization may result in non-coverage or reduced benefits for equipment in excess of $1,000.
	Hospice service	**0%** Coinsurance	**40%** Coinsurance	——————none——————
If you need dental or eye care	Eye exam	**$15** copay	**40%** Coinsurance	1 routine exam every year
	Glasses	Not Covered	Not Covered	——————none——————
	Dental check-up	Not Covered	Not Covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care
- Long-term care
- Routine foot care
- Weight Loss programs
- Private-duty Nursing

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery (Only for Morbid obesity)
- Chiropractic Care (Manipulative Treatment)
- Infertility treatment (Limited to $5,000 per covered person per lifetime)
- Hearing aids
- Routine Eye Care
- Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-747-1137. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: 1-855-747-1137.

Language Access Services:

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoołwoł íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'ałníhí ya sidáhí bich'į naabídíílkiid. Eí doo biigha daago ni ba'nija'go ho'aałagíí bich'į hodiilní. Hai'dąą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'į hodiilní.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,590
- **Patient pays** $950

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$250
Copays	$20
Coinsurance	$510
Limits or exclusions	$170
Total	**$950**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $1,950
- **Patient pays** $3,450

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$250
Copays	$150
Coinsurance	$120
Limits or exclusions	$2,930
Total	**$3,450**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Anthem BlueCross BlueShield

UNIVERSITY OF LOUISVILLE

Your Summary of Benefits

PCA High PPO

(HRA High Medical Plan with HealthEquity)

Network includes University of Louisville and Blue Cross Blue Shield PPO Providers

Anthem Blue Cross and Blue Shield and University of Louisville want to help you take control and make the most of your health care benefits. That's why we provide convenient services to get your health care questions answered quickly and accurately:

- **Anthem.com** – Take advantage of easy, time-saving online tools. You can check your eligibility, benefits, claims, claim payments, search for a doctor, hospital and much more.
- **24/7 NurseLine** – Always there for you. A nurse is a phone call away as well as other health resources, all available 24-hours a day, 7-days a week to provide you with information that can help you make informed decisions. Call toll free at **888.279.5378**.
- **Customer Care** telephone support – Need more help? Contact your designated member services team at **855.747.1137**. Get answers to your benefit questions or receive guidance when looking for a doctor or hospital.

The **Benefit Summary** is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary conflicts in any way with the Summary Plan Description (SPD), the SPD shall prevail. It is recommended that you review your SPD for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

Plan Highlights

Types of Coverage	Network Benefits	Non-Network Benefits
Annual Deductible (Member copayments do not accumulate towards the deductible)		
Individual Deductible Family Deductible	$1,000 per year $3,000 per year	$2,000 per year $6,000 per year
Out-of-Pocket Maximum (Member copayments for Pharmacy does not accumulate towards the Out-of-Pocket Maximum)		
Individual Out-of-Pocket Maximum Family Out-of-Pocket Maximum	$4,000 per year $9,000 per year	$8,000 per year $18,000 per year
Personal Care Account		
Annual Allowances that can be applied per year toward the member's portion of covered medical costs, such as plan deductibles or coinsurance: $500 – Employee $1,000 – Employee + Spouse $2,000 – Employee + Child(ren) $2,000 – Employee + Family		
Benefit Plan Coinsurance (The amount the Plan pays)		
	90% after Deductible has been met	60% after Deductible has been met
Lifetime Maximum Benefit		
There is no dollar limit to the amount the Plan will pay for essential benefits during the entire period you are enrolled in this Plan.	No lifetime maximum benefit	No lifetime maximum benefit
Prescription Drug Benefits		
Prescription drug benefits are shown under separate cover.		
Information of Precertification		
Precertification is required for certain services. Please refer to Benefit Plan Document.		
Information on Benefit Limits		
The annual deductible, out-of-pocket maximum and benefit limits are calculated on a calendar year basis. All benefits are reimbursed based on eligible expenses. For a definition of eligible expenses, please refer to your plan SPD. In network deductible and out of pocket amounts apply to the out of network accumulations. However, out of network deductible and out of pocket do not apply to in network.		

Benefits

Types of Coverage	Network Benefits	Non-Network Benefits
Ambulance Services (Emergency and non-emergency)		
	90% after deductible has been met	90% after network deductible has been met Notification required for non-emergency ambulance services
Dental Services (Accident only)		
	90% after deductible has been met	90% after network deductible has been met
Durable Medical Equipment (DME)		
	90% after deductible has been met	60% after deductible has been met
Emergency Health Services - Outpatient		
	90% after deductible has been met	90% after network deductible has been met for Emergency 60% after network deductible has been met for Non-Emergency
Hearing Aids		
One per ear every 36 months	90% after deductible has been met	60% after deductible has been met
Home Health Care		
Benefits are limited to 100 visits per year	90% after deductible has been met	60% after deductible has been met
Hospice Care		
	90% after deductible has been met	60% after deductible has been met
Hospital Inpatient Stay		
	90% after deductible has been met	60% after deductible has been met
Lab, X-Ray and Major Diagnostics – Outpatient		
Lab X-Ray and Diagnostics	100% coverage 90% after deductible has been met	60% after deductible has been met
Lab, X-Ray and Major Diagnostics – Outpatient (CT, PET, MRI and Nuclear Medicine)		
	90% after deductible has been met	60% after deductible has been met
Mental Health Services		
	90% after deductible has been met	60% after deductible has been met
Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders		
	90% after deductible has been met	60% after deductible has been met
Pharmaceutical Products - Outpatient		
This includes medications administered in an outpatient setting, in the physician's office and by a home health agency.	90% after deductible has been met	60% after deductible has been met
Physician Fees for Surgical and Medical Services		
	90% after deductible has been met	60% after deductible has been met

Types of Coverage	Network Benefits	Non-Network Benefits
Physician's Office Services – Sickness and Injury		
Primary Physician	90% after deductible has been met; University of Louisville Primary Care Physicians will apply a $20 discount off the normal network discount	60% after deductible has been met
Specialist Physician	90% after deductible has been met	60% after deductible has been met
Pregnancy – Maternity Services		
Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each covered Health Service category in this Benefit Summary.	Infertility treatment (Limited to $5,000 per lifetime)	Pre-certification is required if inpatient stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.
Preventive Care Services (Covered health services include but are not limited to:)		
Primary Physician Office Visit	100% - deductible does not apply	60% after deductible has been met
Specialist Physician Office Visit	100% - deductible does not apply	60% after deductible has been met
Lab, X-Ray or other preventive tests	100% - deductible does not apply	60% after deductible has been met
Prosthetic Devices		
	90% after deductible has been met	60% after deductible has been met
Reconstructive Procedures		
Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.		Precertification is required for certain services
Rehabilitation Services – Outpatient Therapy and Manipulative Treatment		
Benefits are limited as follows: 50 visits combined of physical and occupational therapy 25 visits of speech and cognitive therapy 30 visits of manipulative treatment 25 visits combined of respiratory and pulmonary treatment	90% after deductible has been met	60% after deductible has been met
Scopic Procedures – Outpatient Diagnostic and Therapeutic		
Diagnostic scopic procedures include, but are not limited to: Colonoscopy; Sigmoidoscopy; Endoscopy. For Preventive Scopic Procedures, refer to the Preventive Care Services category.	90% after deductible has been met	60% after deductible has been met
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services		
Benefits are limited as follows: 120 days per year	90% after deductible has been met	60% after deductible has been met
Substance Use Disorder Services		
	90% after deductible has been met	60% after deductible has been met
Surgery – Outpatient		
	90% after deductible has been met	60% after deductible has been met

Types of Coverage	Network Benefits	Non-Network Benefits
Transplantation Services		
For network benefits, services must be received at a Blue Distinction Center for Transplant.	90% after deductible has been met	60% after deductible has been met
Urgent Care Center Services		
	90% after deductible has been met	60% after deductible has been met
Vision Examinations		
One Routine Exam per year	90% after deductible has been met;	60% after deductible has been met

Medical Notes

- It is recommended that you review your SPD for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.
- In network deductibles and out of pocket amounts apply to the out of network accumulations. However, out of network deductible and out of pocket amounts are not included in the in network accumulations.
- **Dependent Age:** to the end of the calendar year the child attains age 26.
- When choosing a non-network provider, the member is responsible for any balance due after the plan payment.
- **Benefit Period**: Equals calendar year
- **Behavioral Health Services:** Mental Health and Substance Abuse benefits provided in accordance with the Federal Mental Health Parity.
- **Precertification**: Members are encouraged to always obtain prior approval when using non network providers. Precertification will help avoid any unnecessary reduction in benefits for non-covered or non-medically necessary services.
- **Primary Care Physician:** Network Provider who is a practitioner that specializes in family and general practice, internal medicine and pediatrics.
- **Specialist Physician**: Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.
- **Preventive Care Services** that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits are covered.

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual/Family| **Plan Type:** HRA

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com or by calling 1-855-747-1137.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,000** Individual/ **$3,000** Family for Network providers. **$2,000** Individual/ **$6,000** Family for Non-Network providers.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible.**
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$4,000** Individual/ **$9,000** Family for Network providers. **$8,000** Individual/ **$18,000** Family for Non-Network providers. Pharmacy Max Out of Pocket; In-Network **$2,600** Individual/ **$4,200** Family. Non-Network; **Unlimited** Individual/Family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, Balance-billed charges and Health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit.**
Is there an overall annual limit on what	No. This policy has no overall annual limit on the amount it will	

the plan pays?	pay each year. This HRA account reimburses you for certain deductibles and coinsurance amounts up to **$500** for Employee or **$1,000** for Employee + Spouse or **$2,000** for Employee + Child(ren) or **$2,000** for Employee + Family	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes.See www.anthem.com or call **1-855-747-1137** for a list of Network providers.	If you use an in-network doctor or other health care **provider,** this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred,**or participating for **providers** in their **network.**See the chart starting on page 2 for how this plan pays different kinds of **providers.**
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about **excluded services.**

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use Network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	**10%** Coinsurance	**40%** Coinsurance	$20 discount off the normal network discount applies to University of Louisville Primary Care Physicians
	Specialist visit	**10%** Coinsurance	**40%** Coinsurance	————————none————————
	Other practitioner office visit	**10%** Coinsurance for Manipulative Treatment	**40%** Coinsurance for Manipulative Treatment	Coverage is limited to 30 visits combined Network and Non-Network for Manipulative Treatment. Acupuncture is Not Covered.
	Preventive care/screening/immunization	100% Coverage	**40%** Coinsurance	————————none————————
If you have a test	Diagnostic test (lab, blood work)	**100%** Coverage	**40%** Coinsurance	Failure to obtain pre-authorization may result in non-coverage or reduced benefits for below services. Diagnosis of Sleep Disorders, Gene Expression Profiling for Managing Breast Cancer Treatment and Genetic Testing for Cancer Susceptibility.
	Imaging (x-ray, CT/PET scans, MRIs)	**10%** Coinsurance	**40%** Coinsurance	Failure to obtain pre-authorization may result in non-coverage or reduced benefits for below service. MRI Guided High Intensity Focused Ultrasound Ablation of Uterine Fibroids.

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual/Family| **Plan Type:** HRA

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.anthem.com.	Typically Generic drugs	**$8** Copayment	**$8** Copayment	
	Typically Preferred brand drugs	**25%** Coinsurance	**25%** Coinsurance	A maximum coinsurance amount of $60 applies to each prescription.
	Typically Non-preferred brand drugs	**40%** Coinsurance	**40%** Coinsurance	A maximum coinsurance amount of $100 applies to each prescription.
	Typically Specialty drugs	Follows above.	Follows above.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**10%** Coinsurance	**40%** Coinsurance	Failure to obtain pre-authorization may result in non-coverage or reduced benefits for below surgery. Gender Reassignment Surgery: Human Organ and Bone Marrow/Stem Cell Transplants. Please call the plan for excluded details
	Physician/surgeon fees	**10%** Coinsurance	**40%** Coinsurance	————————none————————
If you need immediate medical attention	Emergency room services	**10%** Coinsurance	**10%** Coinsurance **40%** Coinsurance Non Emergency	Failure to obtain pre-authorization if require notification no later than 2 business days after admission may result in non-coverage or reduced benefits.
	Emergency medical transportation	**10%** Coinsurance	**10%** Coinsurance	Failure to obtain pre-authorization may result in non-coverage or reduced benefits for Air Ambulance (excludes 911 initiated emergency transport).
	Urgent care	**10%** Coinsurance	**40%** Coinsurance	————————none————————

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual/Family| **Plan Type:** HRA

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Non-Network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	**10%** Coinsurance	**40%** Coinsurance	Failure to obtain preauthorization may result in non-coverage or reduced benefits.
	Physician/surgeon fee	**10%** Coinsurance	**40%** Coinsurance	————————none————————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	**10%** Coinsurance	**40%** Coinsurance	Failure to obtain pre-authorization may result in non-coverage or reduced benefits for Intensive Outpatient therapy(IOP).
	Mental/Behavioral health inpatient services	**10%** Coinsurance	**40%** Coinsurance	Failure to obtain preauthorization may result in non-coverage or reduced benefits.
	Substance use disorder outpatient services	**10%** Coinsurance	**40%** Coinsurance	Failure to obtain pre-authorization may result in non-coverage or reduced benefits for Intensive Outpatient therapy(IOP).
	Substance use disorder inpatient services	**10%** Coinsurance	**40%** Coinsurance	Failure to obtain preauthorization may result in non-coverage or reduced benefits.
If you are pregnant	Prenatal and postnatal care	**10%** Coinsurance	**40%** Coinsurance	Your doctor's charges for delivery are part of prenatal and postnatal care.
	Delivery and all inpatient services	**10%** Coinsurance	**40%** Coinsurance	Applies to inpatient facility. Other cost shares may apply depending on the services provided. Failure to obtain pre-authorization may result in non-coverage or reduced benefits for OB delivery stays beyond the Federal Mandate minimum LOS (including newborn stays beyond the mother's stay).

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual/Family| **Plan Type:** HRA

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	**10%** Coinsurance	**40%** Coinsurance	Coverage is limited to 100 visits per calendar year combined Network and Non-Network.
	Rehabilitation services	**10%** Coinsurance	**40%** Coinsurance	Coverage is limited to 50 visits combined Network and Non-Network combined for Occupational and Physical Therapy. Coverage is limited to 25 visits combined Network and Non-Network for Speech Therapy. Coverage is limited to 25 visits combined Network and Non-Network for Pulmonary Therapy including Respiratory. Pre-authorization may be required after the initial twelve (12) visits. Please refer to the benefit plan document for specific details.
	Habilitation services	**10%** Coinsurance	**40%** Coinsurance	All Rehabilitation and Habilitation visits count towards your Rehabilitation visit limit. Pre-authorization may be required after the initial twelve (12) visits. Please refer to the benefit plan document for specific details.
	Skilled nursing care	**10%** Coinsurance	**40%** Coinsurance	Coverage is limited to 120 days combined Network and Non-Network per calendar year. Failure to obtain preauthorization may result in non-coverage or reduced benefits.

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual/Family| **Plan Type:** HRA

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Non-Network Provider	Limitations & Exceptions
	Durable medical equipment	**10%** Coinsurance	**40%** Coinsurance	Failure to obtain preauthorization may result in non-coverage or reduced benefits for equipment in excess of $1,000.
	Hospice service	**10%** Coinsurance	**40%** Coinsurance	——————none——————
If you need dental or eye care	Eye exam	**10%** Coinsurance	**40%** Coinsurance	1 routine eye exam per year
	Glasses	Not Covered	Not Covered	——————none——————
	Dental check-up	Not Covered	Not Covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care
- Long-term care
- Routine foot care
- Weight Loss programs
- Private-duty Nursing

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery (Only for Morbid Obesity)
- Chiropractic Care (Manipulative Treatment)
- Hearing aids
- Infertility treatment (Limited to $5,000 per lifetime)
- Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide
- Routine Eye Care

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-747-1137. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: 1-855-747-1137.

Language Access Services:

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoołwoł íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'ałníhí ya sidáhí bich'į naabídíiłkiid. Eí doo biigha daago ni ba'nija'go ho'aałagíí bich'į hodiilní. Hai'dąą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'į hodiilní.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

* This is a health account based medical plan. This means you have health account that you can use to help pay for eligible medical expenses such as certain deductibles and coinsurance.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,740*
- **Patient pays** $1,800*

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,000
Copays	$0
Coinsurance	$630
Limits or exclusions	$170
Total	**$1,800**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $1,330*
- **Patient pays** $4,070*

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,000
Copays	$0
Coinsurance	$140
Limits or exclusions	$2,930
Total	**$4,070**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Your Summary of Benefits

PCA Low PPO

(HRA Low Medical Plan with HealthEquity)

Network includes University of Louisville and Blue Cross and Blue Shield PPO Providers

Anthem Blue Cross and Blue Shield and University of Louisville want to help you take control and make the most of your health care benefits. That's why we provide convenient services to get your health care questions answered quickly and accurately:

- **Anthem.com** – Take advantage of easy, time-saving online tools. You can check your eligibility, benefits, claims, claim payments, search for a doctor, hospital and much more.
- **24/7 NurseLine** – Always there for you. A nurse is a phone call away as well as other health resources, all available 24-hours a day, 7-days a week to provide you with information that can help you make informed decisions. Call toll free at **888.279.5378**.
- **Customer Care** telephone support – Need more help? Contact your designated member services team at **855.747.1137**. Get answers to your benefit questions or receive guidance when looking for a doctor or hospital.

The **Benefit Summary** is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary conflicts in any way with the Summary Plan Description (SPD), the SPD shall prevail. It is recommended that you review your SPD for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

Plan Highlights

Types of Coverage	Network Benefits	Non-Network Benefits
Annual Deductible (Member copayments do not accumulate towards the deductible)		
Individual Deductible Family Deductible	$2,000 per year $4,000 per year	$4,000 per year $8,000 per year
Out-of-Pocket Maximum (Member copayments for Pharmacy do not accumulate towards the Out-of-Pocket Maximum)		
Individual Out-of-Pocket Maximum Family Out-of-Pocket Maximum	$5,000 per year $10,000 per year	$10,000 per year $20,000 per year
Personal Care Account		
Annual Allowances that can be applied per year toward the member's portion of covered medical costs, such as plan deductibles or coinsurance: $500 – Employee $1,000 – Employee + Spouse $2,000 – Employee + Child(ren) $2,000 – Employee + Family		
Benefit Plan Coinsurance (The amount the Plan pays)		
	80% after Deductible has been met	50% after Deductible has been met
Lifetime Maximum Benefit		
There is no dollar limit to the amount the Plan will pay for essential benefits during the entire period you are enrolled in this Plan.	No lifetime maximum benefit	No lifetime maximum benefit
Prescription Drug Benefits		
Prescription drug benefits are shown under separate cover.		
Information of Precertification		
Precertification is required for certain services. Please refer to your Benefit Plan Document.		
Information on Benefit Limits		
The annual deductible, out-of-pocket maximum and benefit limits are calculated on a calendar year basis. All benefits are reimbursed based on eligible expenses. For a definition of eligible expenses, please refer to your plan SPD. In network deductible and out of pocket amounts apply to the out of network accumulations. However, out of network deductible and out of pocket do not apply to in network.		

Benefits

Types of Coverage	Network Benefits	Non-Network Benefits
Ambulance Services (Emergency and non-emergency)		
	80% after deductible has been met	80% after network deductible has been met Notification required for non-emergency ambulance services
Dental Services (Accident only)		
	80% after deductible has been met	80% after network deductible has been met
Durable Medical Equipment (DME)		
	80% after deductible has been met	50% after deductible has been met
Emergency Health Services - Outpatient		
	80% after deductible has been met	80% after network deductible has been met Emergency 50% after deductible has been met for Non-Emergency
Hearing Aids		
One per ear every 36 months	80% after deductible has been met	50% after deductible has been met
Home Health Care		
Benefits are limited to 100 visits per year	80% after deductible has been met	50% after deductible has been met
Hospice Care		
	80% after deductible has been met	50% after deductible has been met
Hospital Inpatient Stay		
	80% after deductible has been met	50% after deductible has been met
Lab, X-Ray and Major Diagnostics – Outpatient		
Lab X-Ray and Diagnostics	100% coverage 80% after deductible has been met	50% after deductible has been met
Lab, X-Ray and Major Diagnostics – Outpatient (CT, PET, MRI and Nuclear Medicine)		
	80% after deductible has been met	50% after deductible has been met
Mental Health Services		
	80% after deductible has been met	50% after deductible has been met
Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders		
	80% after deductible has been met	50% after deductible has been met
Pharmaceutical Products - Outpatient		
This includes medications administered in an outpatient setting, in the physician's office and by a home health agency.	80% after deductible has been met	50% after deductible has been met
Physician Fees for Surgical and Medical Services		
	80% after deductible has been met	50% after deductible has been met

Types of Coverage	Network Benefits	Non-Network Benefits
Physician's Office Services – Sickness and Injury		
Primary Physician	80% after deductible has been met; University of Louisville Primary Care Physicians will apply a $20 discount off the normal network discount	50% after deductible has been met
Specialist Physician	80% after deductible has been met	50% after deductible has been met
Pregnancy – Maternity Services		
Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each covered Health Service category in this Benefit Summary.	Infertility treatment (Limited to $5,000 per lifetime)	Precertification is required if inpatient stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.
Preventive Care Services (Covered health services include but are not limited to:)		
Primary Physician Office Visit	100% - deductible does not apply	50% after deductible has been met
Specialist Physician Office Visit	100% - deductible does not apply	50% after deductible has been met
Lab, X-Ray or other preventive tests	100% - deductible does not apply	50% after deductible has been met
Prosthetic Devices		
	80% after deductible has been met	50% after deductible has been met
Reconstructive Procedures		
Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.		Precertification is required for certain services
Rehabilitation Services – Outpatient Therapy and Manipulative Treatment		
Benefits are limited as follows: 50 visits combined of physical and occupational therapy 25 visits of speech and cognitive therapy 30 visits of manipulative treatment 25 visits combined of respiratory and pulmonary treatment	80% after deductible has been met	50% after deductible has been met
Scopic Procedures – Outpatient Diagnostic and Therapeutic		
Diagnostic scopic procedures include, but are not limited to: Colonoscopy; Sigmoidoscopy; Endoscopy. For Preventive Scopic Procedures, refer to the Preventive Care Services category.	80% after deductible has been met	50% after deductible has been met
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services		
Benefits are limited as follows: 120 days per year	80% after deductible has been met	50% after deductible has been met
Substance Use Disorder Services		
	80% after deductible has been met	50% after deductible has been met
Surgery – Outpatient		
	80% after deductible has been met	50% after deductible has been met

Types of Coverage	Network Benefits	Non-Network Benefits
Transplantation Services		
For network benefits, services must be received at a Blue Distinction Center for Transplant.	80% after deductible has been met	50% after deductible has been met
Urgent Care Center Services		
	80% after deductible has been met	50% after deductible has been met
Vision Examinations		
Benefits are limited as follows: 1 routine exam every year	80% after deductible has been met	50% after deductible has been met

Medical Notes

- It is recommended that you review your SPD for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.
- In network deductibles and out of pocket amounts apply to the out of network accumulations. However, out of network deductible and out of pocket amounts are not included in the in network accumulations.
- **Dependent Age:** to the end of the calendar year the child attains age 26.
- When choosing a non-network provider, the member is responsible for any balance due after the plan payment.
- **Benefit Period**: Equals calendar year
- **Behavioral Health Services:** Mental Health and Substance Abuse benefits provided in accordance with the Federal Mental Health Parity.
- **Precertification**: Members are encouraged to always obtain prior approval when using non network providers. Precertification will help avoid any unnecessary reduction in benefits for non-covered or non-medically necessary services.
- **Primary Care Physician:** Network Provider who is a practitioner that specializes in family and general practice, internal medicine and pediatrics.
- **Specialist Physician**: Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.
- **Preventive Care Services** that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits are covered.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com or by calling 1-855-747-1137.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$2,000** Individual/ **$4,000** Family for Network providers. **$4,000** Individual/ **$8,000** Family for Non-Network providers.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible.**
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$5,000** Individual/ **$10,000** Family for Network providers. **$10,000** Individual/ **$20,000** Family for Non-Network providers. Pharmacy Max Out of Pocket; In-Network **$1,600** Individual/ **$3,200** Family. Non-Network; **Unlimited** Individual/Family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, Balance-billed charges and Health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit.**
Is there an overall annual limit on what the plan pays?	No. This policy has no overall annual limit on the amount it will pay each year. This HRA account reimburses you for certain	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.

	deductibles and coinsurance amounts up to **$500** for Employee or **$1,000** for Employee + Spouse or **$2,000** for Employee + Child(ren) or **$2,000** for Employee + Family	
Does this plan use a network of providers?	Yes.See www.anthem.com or call **1-855-747-1137** for a list of Network providers.	If you use an in-network doctor or other health care **provider,** this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred,**or participating for **providers** in their **network.**See the chart starting on page 2 for how this plan pays different kinds of **providers.**
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about **excluded services.**

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use Network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	**20%** Coinsurance	**50%** Coinsurance	$20 discount off the normal network discount applies to University of Louisville Primary Care Physicians
	Specialist visit	**20%** Coinsurance	**50%** Coinsurance	————————none————————
	Other practitioner office visit	**20%** Coinsurance for Manipulative Treatment	**50%** Coinsurance for Manipulative Treatment	Coverage is limited to 30 visits combined Network and Non-Network providers for Manipulative Treatment.
	Preventive care/screening/immunization	100% Coverage	**50%** Coinsurance	————————none————————
If you have a test	Diagnostic test (lab, blood work)	**100%** Coverage	**50%** Coinsurance	Failure to obtain pre-authorization may result in non-coverage or reduced benefits for below services. Diagnosis of Sleep Disorders, Gene Expression Profiling for Managing Breast Cancer Treatment and Genetic Testing for Cancer Susceptibility.
	Imaging (X-Rays, CT/PET scans, MRIs)	**20%** Coinsurance	**50%** Coinsurance	Failure to obtain pre-authorization may result in non-coverage or reduced benefits for below service. MRI Guided High Intensity Focused Ultrasound Ablation of Uterine Fibroids.
If you need drugs to treat your illness or condition More information	Typically Generic drugs	**$8** Copayment	**$8** Copayment	
	Typically Preferred brand drugs	**25%** Coinsurance	**25%** Coinsurance	A maximum coinsurance amount of $60 applies to each prescription.
	Typically Non-preferred brand drugs	**40%** Coinsurance	**40%** Coinsurance	A maximum coinsurance amount of $100 applies to each prescription.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
about **prescription drug coverage** is available at **www.[insert]**	Typically Specialty drugs	Follows above.	Follows above.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**20%** Coinsurance	**50%** Coinsurance	Failure to obtain pre-authorization may result in non-coverage or reduced benefits for below surgery. Gender Reassignment Surgery: Human Organ and Bone Marrow/Stem Cell Transplants. Please call the plan for excluded details.
	Physician/surgeon fees	**20%** Coinsurance	**50%** Coinsurance	————————none————————
If you need immediate medical attention	Emergency room services	**20%** Coinsurance	**20%** Coinsurance **50%** Coinsurance for Non Emergency	Failure to obtain pre-authorization if require notification no later than 2 business days after admission may result in non-coverage or reduced benefits.
	Emergency medical transportation	**20%** Coinsurance	**20%** Coinsurance	Failure to obtain pre-authorization may result in non-coverage or reduced benefits for Air Ambulance (excludes 911 initiated emergency transport).
	Urgent care	**20%** Coinsurance	**50%** Coinsurance	————————none————————
If you have a hospital stay	Facility fee (e.g., hospital room)	**20%** Coinsurance	**50%** Coinsurance	Failure to obtain pre-authorization may result in non-coverage or reduced benefits.
	Physician/surgeon fee	**20%** Coinsurance	**50%** Coinsurance	————————none————————

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	**20%** Coinsurance	**50%** Coinsurance	Failure to obtain pre-authorization may result in non-coverage or reduced benefits for Intensive Outpatient therapy(IOP).
	Mental/Behavioral health inpatient services	**20%** Coinsurance	**50%** Coinsurance	Failure to obtain pre-authorization may result in non-coverage or reduced benefits.
	Substance abuse disorder outpatient services	**20%** Coinsurance	**50%** Coinsurance	Failure to obtain pre-authorization may result in non-coverage or reduced benefits for Intensive Outpatient therapy(IOP).
	Substance abuse disorder inpatient services	**20%** Coinsurance	**50%** Coinsurance	Failure to obtain pre-authorization may result in non-coverage or reduced benefits.
If you are pregnant	Prenatal and postnatal care	**20%** Coinsurance	**50%** Coinsurance	Your doctor's charges for delivery are part of prenatal and postnatal care.
	Delivery and all inpatient services	**20%** Coinsurance	**50%** Coinsurance	Applies to inpatient facility. Other cost shares may apply depending on the services provided. Failure to obtain pre-authorization may result in non-coverage or reduced benefits for OB delivery stays beyond the Federal Mandate minimum LOS (including newborn stays beyond the mother's stay).

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	**20%** Coinsurance	**50%** Coinsurance	Coverage is limited to 100 visits per calendar year combined Network and Non-Network providers.
	Rehabilitation services	**20%** Coinsurance	**50%** Coinsurance	Coverage is limited to 50 visits combined Network and Non-Network combined for Occupational and Physical Therapy. Coverage is limited to 25 visits combined Network and Non-Network for Speech Therapy. Coverage is limited to 25 visits combined Network and Non-Network for Pulmonary Therapy including Respiratory. Pre-authorization may be required after the initial twelve (12) visits. Please refer to the benefit plan document for specific details..
	Habilitation services	**20%** Coinsurance	**50%** Coinsurance	All Rehabilitation and Habilitation visits count towards your rehabilitation visit limit. Pre-authorization may be required after the initial twelve (12) visits. Please refer to the benefit plan document for specific details.
	Skilled nursing care	**20%** Coinsurance	**50%** Coinsurance	Coverage is limited to 120 days per calendar year combined Network and Non-Network providers. Failure to obtain pre-authorization may result in non-coverage or reduced benefits.
	Durable medical equipment	**20%** Coinsurance	**50%** Coinsurance	Failure to obtain pre-authorization may result in non-coverage or reduced benefits.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Hospice service	**20%** Coinsurance	**50%** Coinsurance	————————none————————
If you need dental or eye care	Eye exam	**20%** Coinsurance	**50%** Coinsurance	1 routine eye exam per year
	Glasses	Not Covered	Not Covered	————————none————————
	Dental check-up	Not Covered	Not Covered	————————none————————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Long-term care
- Dental care
- Routine foot care
- Weight Loss programs
- Private-duty Nursing

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery (Only for Morbid Obesity)
- Chiropractic Care (Manipulative Treatment)
- Hearing aids
- Infertility treatment (Coverage is limited to $5,000 per covered person per lifetime`)
- Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide
- Routine Eye Care

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-747-1137. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: 1-855-747-1137.

Language Access Services:

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoołwoł íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'ałníhí ya sidáhí bich'į naabídíiłkiid. Eí doo biigha daago ni ba'nija'go ho'aałagíí bich'į hodiilní. Hai'dąą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'į hodiilní.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.
* This is a health account based medical plan. This means you have health account that you can use to help pay for eligible medical expenses such as certain deductibles and coinsurance.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,370*
- **Patient pays** $3,170*

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,000
Copays	$0
Coinsurance	$1,000
Limits or exclusions	$170
Total	**$3,170**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $390*
- **Patient pays** $5,010*

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$2,000
Copays	$0
Coinsurance	$80
Limits or exclusions	$2,930
Total	**$5,010**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

HumanaDental PPO 09

HUMANA. Specialty Benefits

KENTUCKY

University of Louisville

	If you use IN-NETWORK provider		If you use OUT-OF-NETWORK provider	
Calendar-year deductible (excludes orthodontia services)	Individual $25	Family $75	Individual $25	Family $75
Annual maximum (excludes orthodontia services)	$1,000 After you reach the annual maximum amount, you will receive 30 percent coinsurance on preventive, basic, and major services for the rest of the plan year. (Implants and orthodontia excluded.)			
Preventive services • Oral examinations • X-rays • Cleanings • Topical fluoride treatment • Space maintainers • Sealants	100% no deductible		75% no deductible of in-network fee schedule	
Basic services • Emergency care for pain relief • Basic oral surgery services - basic extractions of erupted tooth or root • Fillings (amalgam, composite for anterior teeth) • Prefabricated stainless steel crowns • Periodontics • Endodontics (root canal) • Complex surgical extractions - surgical removal of erupted tooth, impacted tooth, and tooth roots	80% after deductible		60% after deductible of in-network fee schedule	
Major services • Crowns • Inlays and onlays • Bridgework • Dentures • Denture relines and rebases • Denture repair and adjustments	60% after deductible		40% after deductible of in-network fee schedule	
Orthodontia	Child orthodontia - Covers children through age 26 Plan pays 50 percent (no deductible) of the covered orthodontia services, up to: $1,000 lifetime orthodontia maximum.			

Non-participating dentists can bill you for charges above the amount covered by your HumanaDental plan. To ensure you do not receive additional charges, visit a participating PPO Network dentist.

HumanaDental PPO 09

HUMANA. Specialty Benefits

Questions?

Simply call 1-800-233-4013 to speak with a friendly, knowledgeable Customer Care specialist, or visit **Humana.com**.

Feel good about choosing a HumanaDental plan

Make regular dental visits a priority

Regular cleanings can help manage problems throughout the body such as heart disease, diabetes, and stroke.* Your HumanaDental PPO plan focuses on prevention and early diagnosis, providing four exams and cleanings every calendar year: two regular and two periodontal.

* www.perio.org

Go to MyDentalIQ.com

Take a health risk assessment that immediately rates your dental health knowledge. You'll receive a personalized action plan with health tips. You can print a copy of your scorecard to discuss with your dentist at your next visit.

Tips to ensure a healthy mouth

- Use a soft-bristled toothbrush
- Choose toothpaste with fluoride
- Brush for at least two minutes twice a day
- Floss daily
- Watch for signs of periodontal disease such as red, swollen, or tender gums
- Visit a dentist regularly for exams and cleanings

Did you know that 74 percent of adult Americans believe an unattractive smile could hurt a person's chances for career success?* HumanaDental helps you feel good about your dental health so you can smile confidently.

* American Academy of Cosmetic Dentistry

Use your HumanaDental benefits

Find a dentist

With HumanaDental' s PPO plan, you can see any dentist. You save an average of 28 percent when you visit a dentist in HumanaDental' s PPO Network. To find a dentist in HumanaDental' s PPO Network, log on to **Humana.com** or call 1-800-233-4013.

Know what your plan covers

The other side of this page provides a summary of HumanaDental benefits. Your plan certificate describes in detail your HumanaDental benefits. You can find it on MyHumana, your personal page at **Humana.com** or call 1-800-233-4013.

See your dentist

Your HumanaDental identification card contains all the information your dentist needs to submit your claims. Be sure to share it with the office staff when you arrive for your appointment. If you don't have your card, you can print proof of coverage at **Humana.com**.

Learn what your plan paid

After HumanaDental processes your dental claim, you will receive an explanation of benefits or claims receipt. It provides detailed information on covered dental services, amounts paid, plus any amount you may owe your dentist. You can also check the status of your claim on MyHumana at **Humana.com** or by calling 1-800-233-4013.

HUMANA. Specialty Benefits

Insured or administered by HumanaDental Insurance Company

This is not a complete disclosure of plan qualifications and limitations. Your broker will provide you with specific limitations and exclusions as contained in the Regulatory and Technical Information Guide. Please review this information before applying for coverage. The amount of benefits provided depends upon the plan selected. Premiums will vary according to the selection made.

Schedule of Vision Benefits

Co-payment *$10 Exam / $20 Lenses*	Participating Provider	Non-Participating Provider
Examination Once Every Calendar Year	▪ *Covered 100%* ▪ *After $10 copay*	Reimbursed Amount ▪ *Up to $45*
Lenses Once Every Calendar Year ▪ *Single Vision* ▪ *Bifocal* ▪ *Trifocal* ▪ *Lenticular* ▪ *Polycarbonates (under age 19)*	Standard Glass or Plastic ▪ *Covered 100%* ▪ *After $20 copay*	▪ *Up to $45* ▪ *Up to $55* ▪ *Up to $80* ▪ *Up to $110* ▪ *N/A*
Frame Once Every Two Calendar Years	Retail Allowance ▪ *Up to $120* *(20% discount off balance)**	▪ *Up to $50*
Contact Lenses Once Every Calendar Year Elective Contact Lenses *Medically Necessary****	▪ *Up to $120 Retail①* *(15% discount (Conventional) or 10% discount (Disposable) off balance)*** ▪ *Covered 100%*	▪ *Up to $105* ▪ *Up to $210*

**Does not apply to Wal-Mart / Sam's Club locations*
***Does not apply to Wal-Mart / Sam's Club or Contact Fill locations*
****Pre-approval from NVA required*

①Additional professional services related to contact lenses (also known as fitting fees) would be included in the contact lens allowance shown above.

Lens options purchased from a participating NVA provider will be provided to the member at the amounts listed in the fixed option pricing list below:

- *$10 Solid Tint*
- *$12 Fashion / Gradient Tint*
- *$10 Standard Scratch-Resistant Coating*
- *$12 Ultraviolet Coating*
- *$40 Standard Anti-Reflective*
- *$20 Glass Photogrey (Single Vision)*
- *$30 Glass Photogrey (Multi-Focal)*
- *$75 Polarized*
- *$50 Progressive Lenses Standard*
- *$65 Transitions Single Vision Standard*
- *$70 Transitions Multi-Focal Standard*
- *$25 Polycarbonate (Single Vision) 19 & over*
- *$30 Polycarbonate (Multi-Focal) 19 & over*
- *$30 Blended Bifocal (Segment)*
- *$55 High Index*

Options not listed will be priced by NVA providers at their reasonable & customary retail price less 20%.

Wal-Mart / Sam's Club Stores: Due to their everyday low prices Wal-Mart / Sam's Club will not provide the lens options at the fees listed in the fixed option pricing list. Wal-Mart / Sam's Club stores accept NVA for materials. Doctors affiliated with Wal-Mart / Sam's Club are not Wal-Mart / Sam's Club employees; therefore, participation for exams varies.

This document is intended as a program overview only and is not a certified document of the individual plan parameters.

Iwf607

COUNCIL 13 AFSCME UNION LABEL

National Vision Administrators, L.L.C.

University of Louisville

Summary of Vision Care Benefits

National Vision Administrators, L.L.C. (NVA) has been contracted by your group to offer a comprehensive vision care plan to you and your eligible family members. Founded in January of 1979, NVA manages vision benefit services for approximately seven million lives nationwide. Group Effective 01/01/2012

How Your Vision Care Program Works

- *For your convenience, at the start of the program, you will receive two identification cards with participating providers in your zip code area listed on the back.*
- *When scheduling your appointment, please notify the NVA participating provider of your choice that your vision coverage is administered by NVA.*
- *The provider will contact NVA to verify eligibility.*
- *At the time of your appointment, simply present your NVA identification card to the provider or indicate clearly that your benefit is administered by NVA.* A vision claim form is not required at an NVA participating provider.
- *The provider will inform you of your eligibility status prior to rendering services.*
- *Be sure to inform the provider of your medical history and any prescription or over-the-counter medications you may be taking.*

To verify your benefit eligibility prior to calling or visiting your eye care provider, please visit our website at www.e-nva.com or contact NVA's Customer Service Department toll-free at 1.800.672.7723.

Eligibility: Eligible members and dependents are entitled to receive a vision examination and one (1) pair of lenses once every calendar year and a frame once every two calendar years and contact lenses once every calendar year.

Customer Service: To verify eligibility, locate a participating provider and receive answers to all your vision care related inquiries, please call NVA's Customer Service Department toll-free at 1.800.672.7723 (TDD: 973.574.2599).

- *NVA's Interactive Voice Response (IVR) system is available twenty-four (24) hours per day, seven (7) days per week. The IVR allows you to locate a participating provider in your area, check eligibility as well as the status of your claim(s).*
- *An NVA Customer Service Representative can be contacted twenty-four (24) hours per day, seven (7) days per week.*

National Vision Administrators, L.L.C. ▫ PO Box 2187 ▫ Clifton, NJ 07015
Web: www.e-nva.com ▫ Toll-Free: 1.800.672.7723

This document has been printed on recycled paper.

Benefits at Participating Providers:
Highlights of your vision care benefit:

- The option of receiving services in- or out-of-network
- Extensive national provider network
- Enhanced in-network benefits:
  - *100% covered Vision examination (after copay if applicable)*
  - *100% covered standard spectacle lenses (after copay if applicable)*
  - *Frame allowance covers countless fashionable frames in full*
  - *Allowance towards the cost of contact lenses and fitting fees*
  - *No claim forms; providers will submit claims directly to NVA.*

Examinations*:* The comprehensive exam includes case history, examination for pathology or anomalies, visual acuity (clearness of vision), refraction, tonometry (glaucoma test) and dilation. Comprehensive eye examinations can aid in the early detection of ocular diseases and other serious medical conditions, diabetes and cardiovascular disease for example.

Lenses: NVA provides coverage in full for standard glass or plastic eyeglass lenses.

Frames: Select any frame from the participating provider's inventory. Any amount in excess of your plan allowance is the member's responsibility. Frame choices vary from office to office.

Contact Lenses: The contact lens benefit includes all types of contact lenses such as hard, soft, gas permeable and disposable lenses. Medically necessary contact lenses may be covered with prior authorization when prescribed for: post cataract surgery, correction of extreme visual acuity problems that cannot be corrected to 20/70 with spectacle lenses, Anisometropia or Keratoconus.

Discounts: In addition to your funded benefit you are eligible to access the EyeEssential[SM] Plan discount on additional purchases during the plan period.

Non-Participating Providers: You will be responsible for one hundred percent (100%) of the cost at the time of service at a non-participating provider. To obtain direct reimbursement according to your plan design, you can print a claim form from www.e-nva.com. Please complete this form and submit along with an original or copy of the itemized receipt. If you cannot print the claim form you may submit receipts along with a letter containing the member's full name, patient's full name, address, ID# and sponsoring organization to NVA's Clifton, NJ office. **Remember**, obtaining vision care services from a non-participating provider will result in greater out-of-pocket expense.

Exclusions / Limitations*:* No payment is made for medical or surgical treatments / Rx drugs or OTC medications / non-prescription lenses / two pair of glasses in lieu of bifocals / subnormal visual aids / vision examination or materials required for employment / replacement of lost, stolen, broken or damaged lenses/ contact lenses or frames except at normal intervals when service would otherwise be available / services or materials provided by federal, state, local government or Worker's Compensation / examination, procedures training or materials not listed as a covered service / industrial safety lenses and safety frames with or without side shields / parts or repair of frame / sunglasses.

Participating providers are not contractually obligated to offer sale prices in addition to outlined coverage.

Regardless of medical or optical necessity, vision benefits are not available more frequently than specified in your policy.

Valuable Member Discounts

Laser Eye Surgery: NVA has chosen **The National LASIK Network** to serve their members. This network was developed by **LCA Vision** in 1999 and is one of the largest panels of LASIK surgeons in the U.S.

Members are entitled to significant discounts and a free initial consultation with all in-network providers.

All providers are contracted to extend members discounts on standard prices or promotional prices, ensuring the member will pay less than the public.

- 15% off standard prices - or - 5% off promotional pricing

All-Inclusive Discount

- All in network providers extend the discount on the entire cost of the procedure, maximizing member savings.

Additional Member Value – Members are entitled to these additional benefits available exclusively at select providers (over 70 locations nationwide).

- Special "set prices" ranging from $695 to $1,895 per eye on select technologies.
- Free initial consultation and comprehensive LASIK exam
- Advanced laser technologies including Wavefront and IntraLase (All-Laser LASIK)
- Attractive financing options available

The process is simple:

- *Find a provider (Call 1-877-295-8599 or visit* www.e-nva.com)
- *Schedule a pre-operative exam to determine if laser vision correction is right for you*
- *Schedule a treatment*
- *Pay discounted member price directly to the provider*

Contact Fill: NVA provides you with the convenience and savings of Contact Fill, our mail order contact lens replacement service. You may access Contact Fill's services online at www.contactfill.com or by calling them toll-free at 866.234.1393. Contact Fill provides contact lens wearers with significant savings packaged with the convenience of home delivery. Plan discounts applicable at participating retail locations do not apply to purchases made through Contact Fill due to the already low prices.

Please enter NVAFSNEW for free shipping and handling on your first order. Expires 12-31-15

Plan Specific Details Online: The NVA website is easy to use and provides the most up to date information for program participants:

- *Locate a nearby participating provider by name, zip code, or City/State*
- *Verify eligibility for you or a dependent*
- *View benefit program and specific details*
- *Review claims*
- *Print ID cards (when allowable)*
- *Nominate a non-participating provider to join the NVA network*

If you are not a registered subscriber, you can still search our providers online by selecting the "Find a Provider" link on our home page. Enter group number **51756000001** or the group number on the identification card you will be receiving prior to your effective date and enter in your search parameters. It's that easy!

UNIVERSITY OF LOUISVILLE IS PLEASED TO OFFER SHORT TERM DISABILITY INSURANCE

If you lose the ability to bring home a paycheck, how will you pay your expenses and take care of your family? Even with health insurance you may still have some gaps in coverage. Income Protector, a disability insurance policy, provides a benefit to help supplement lost wages due to a covered off-the-job injury or sickness. You will receive a payment that can be used to cover everything from lost wages to medical expenses.

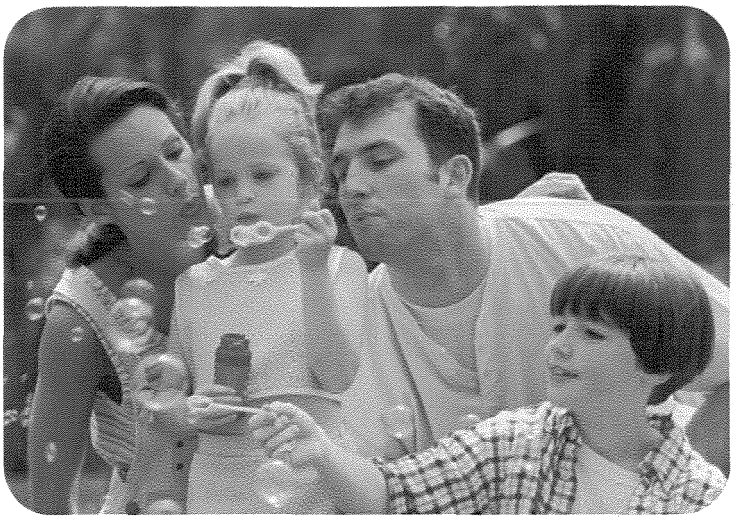
A Plan You Can Count On!

Income Protector offers coverage for the following:

- Coverage begins after a day waiting period
- Pays up to a 6 month benefit for each qualifying event
- Pays in addition to any coverage in place
- Pays up to $3,000 per month, not to exceed 60% of your income
- Covers off the job injuries/sickness
- Pre existing conditions (after 12 months)
- Normal maternity is covered after one year once policy is in effect.
- You own the policy which is fully portable

The Stakes are High.

- Disabilities account for *48% of all mortgage foreclosures.* *[Source: Benefits Selling, September 2004]*
- The chance of a 40 year old having a long-term disability which lasts three months or longer before that person reaches age 65 is 39 to 1. *[Source: No Nonsense Finance, Errold F. Moody c 2004]*
- A 30-year-old woman has a 16% chance of dying before age 65 *but she has a 57% chance of becoming disabled.* *[Source: No Nonsense Finance, Errold F. Moody c 2004]*



Your Family, Your Income and Your Assets Need Protection Now

- Enrollment is easy - only a few questions to answer; and premiums are paid through payroll deduction helping to provide you and your family with insurance protection you need.

How do I sign up for this great benefit?

Please call our call center to enroll or if you have any questions.

502-643-1738

UNIVERSITY of LOUISVILLE
dare to be great

HUMANA
Specialty Benefits

Income Protector is Kanawha Insurance Company Policy Form 80260 8/99. The policy and any optional benefits/riders contain limitations and exclusions. Optional benefits/riders and features are not available in all states and may vary by state. This is only an outline of benefits, not a guarantee of coverage, please see the actual policy for details. Kanawha Insurance Company is a member of the Humana family of companies.

UNIVERSITY OF LOUISVILLE
EMPLOYEE HEALTH INSURANCE PLAN

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed (shared) and how you can get access to this information. Please review it carefully.

The University of Louisville Employee Health Plan has always been committed to maintaining the confidentiality of the personal health information it receives about employees like you. This notice describes how the University of Louisville Employee Health Insurance Plan may use and share the personal health information it receives about you. The University of Louisville Employee Health Insurance Plan will be referred to as the Health Plan for the remainder of this notice, unless specified otherwise. The notice will inform you of how your information may be used or shared (1) without first obtaining your permission; (2) after you have been given an opportunity to object; or (3) only with your permission. This notice also outlines your rights.

THE HEALTH PLAN'S DUTIES WITH RESPECT TO HEALTH INFORMATION ABOUT YOU

The Health Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Health Plan's legal duties and privacy practices with respect to your health information. It is important to note that these rules apply to the Health Plan, not the University of Louisville as an employer. Different policies may apply to other University of Louisville programs or to data unrelated to the Health Plan.

HOW THE HEALTH PLAN MAY USE OR SHARE YOUR HEALTH INFORMATION

The privacy rules generally allow the use and disclosure of your health information without your permission for purposes of health care treatment, payment activities, health care operations and other limited purposes in the public interest. Here are some examples of what that might include:

- **Treatment** includes providing, coordinating, or managing health care by one (1) or more health care providers. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. *For example, the Health Plan may share health information about you with physicians who are treating you.*

- **Payment** includes activities by the Health Plan, to obtain premiums, make coverage determinations and provide reimbursement for health care. This can include verifying your coverage, reviewing services for medical necessity or appropriateness, utilization management activities, claims management, and billing; as well as "behind the scenes" plan functions such as risk adjustment, collection, or reinsurance. *For example, the Health*

Plan may share information about your coverage or the expenses you have incurred with another health plan in order to coordinate payment of benefits.

- **Health care operations** include activities of the Health Plan (and in limited circumstances other plans or providers) such as wellness and risk assessment programs, quality assessment and improvement activities, and customer service. Health care operations also include vendor evaluations, credentialing, training, accreditation activities, underwriting, premium rating, arranging for medical review and audit activities, and business planning and development. *For example, the Health Plan may use information about your claims to review the effectiveness of wellness programs.* The Health Plan cannot use or share your genetic information for underwriting purposes, except for underwriting long-term care policies.

The Health Plan may also contact you to provide information about health-related benefits and services that may be of interest to you.

HOW THE HEALTH PLAN MAY SHARE YOUR HEALTH INFORMATION WITH THE UNIVERSITY OF LOUISVILLE

The Health Plan, or its health insurer or HMO, may share your health information without the need to get your permission to the University of Louisville for plan administration purposes. The University of Louisville may need your health information to administer benefits under the Health Plan. The University of Louisville agrees not to use or disclose your health information other than as permitted or required by the Health Plan documents and by law. The Human Resource-Employee Benefits Unit, university Privacy Officer, Institutional Compliance and Audit Services, and University Counsel are the only University of Louisville employees who will have access to your health information for plan administration functions.

Here is how additional information may be shared between the Health Plan and the University of Louisville:

- The Health Plan, or its Insurer or HMO, may disclose "summary health information" to the University of Louisville, if requested, for purposes of obtaining premium bids to provide coverage under the Health Plan, or for modifying, amending, or terminating the Health Plan. Summary health information is information that summarizes participants' claims information, but from which names and other identifying information has been removed.

- The Health Plan, or its Insurer or HMO, may disclose to University of Louisville information on whether an individual is participating in the Health Plan, or has enrolled or disenrolled in an insurance option or HMO offered by the Health Plan.

In addition, you should know that the University of Louisville cannot and will not use health information obtained from the Health Plan for any employment-related actions. However, health information collected by the University of Louisville from other sources, for example under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation is *not* protected under HIPAA (although this type of information may be protected under other federal or state laws).

OTHER WAYS YOUR HEALTH INFORMATION MAY BE USED OR SHARED

The Health Plan is also allowed to use or share your health information without getting your permission for the following activities:

Workers' compensation	Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with such laws
Necessary to prevent serious threat to health or safety	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (including disclosures to the target of the threat); includes disclosures to assist law enforcement officials in identifying or apprehending an individual because the individual has made a statement admitting participation in a violent crime that the Health Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody
Public health activities	Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects
Victims of abuse, neglect, or domestic violence	Disclosures to government authorities, including social services or protected services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Health Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Health Plan's disclosure if informing you won't put you at further risk)
Judicial and administrative proceedings	Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the Health Plan may be required to notify you of the request, or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)
Law enforcement purposes	Disclosures to law enforcement officials required by law or pursuant to legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosure about a death that may have resulted from criminal conduct; and disclosure to provide evidence of criminal conduct on the Health Plan's premises
Decedents	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties

Organ, eye, or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death
Research purposes	Disclosures subject to approval by institutional or private privacy review boards, and subject to certain assurances and representations by researchers regarding necessity of using your health information and treatment of the information during a research project
Health oversight activities	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws
Specialized government functions	Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates
HHS investigations	Disclosures of your health information to the Department of Health and Human Services (HHS) to investigate or determine the Health Plan's compliance with HIPAA

Other uses and sharing of your health information that are not described in this notice will be made only with your written permission, called an Authorization. Examples where your Authorization is required include:

- Most uses or sharing of psychotherapy notes
- Using or sharing your health information for marketing purposes
- For some situations in which we receive payment for sharing your information

You can revoke your Authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any sharing of information made with your Authorization before it was revoked.

WAYS YOUR HEALTH INFORMATION MAY BE USED OR SHARED IF YOU HAVE HAD A CHANCE TO OBJECT

Your health information may be shared with a family member, close friend, or other person if they are involved in your care or the payment for your care. Information describing your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You will generally be given the chance to agree or object to these disclosures. Exceptions may be made, for example, if you are not present or if you are incapacitated.

YOUR INDIVIDUAL RIGHTS

You have the following rights with respect to your health information the Health Plan maintains. This section of the notice describes how you may exercise each individual right. Any request to

exercise one of the rights listed below must be made in writing to **Employee Benefits, 1980 Arthur St, Suite 100, Louisville, KY 40208.**

RIGHT TO REQUEST RESTRICTIONS ON CERTAIN USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

You have the right to ask the Health Plan to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law. You have the right to ask the Health Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Health Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts.

The Health Plan is not required to agree to a requested restriction. And if the Health Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Health Plan (including an oral agreement), or unilaterally by the Health Plan for health information created or received after you are notified that the Health Plan has removed the restrictions. The Health Plan may also disclose health information about you if you need emergency treatment, even if the Health Plan has agreed to a restriction.

RIGHT TO RECEIVE CONFIDENTIAL COMMUNICATIONS OF YOUR HEALTH INFORMATION

If you think that disclosure of your health information by the usual means could endanger you in some way, the Health Plan will accommodate reasonable requests to receive communications of health information from the Health Plan by alternative means or at alternative locations. Your written request must include a statement that disclosure of all or part of the information could endanger you.

RIGHT TO INSPECT AND COPY YOUR HEALTH INFORMATION

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "Designated Record Set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Health Plan uses to make decisions about individuals. There are certain elements of your medical record you do not have the right to access. There are certain other reasons that the Health Plan can deny you access to your health information.

In response to your written request Health Plan will provide you with:

- The access or copies you requested;
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint; or

The Health Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Health Plan may also charge reasonable fees for copies or postage.

If the Health Plan does not maintain the health information but knows where it is maintained, you will be informed of where to direct your request.

RIGHT TO AMEND YOUR HEALTH INFORMATION THAT IS INACCURATE OR INCOMPLETE

With certain exceptions, you have a right to request that the Health Plan amend your health information in a Designated Record Set. The Health Plan may deny your request for a number of reasons.

Any written request to amend your record must state the information you believe is inaccurate or incomplete and what you believe to be the accurate or complete information. In response to your request, the Health Plan will:

- Make the change as requested; or
- Provide a written denial that explains why your request was denied and any rights you may have to disagree, respond to the denial or file a complaint.

RIGHT TO RECEIVE AN ACCOUNTING OF DISCLOSURES OF YOUR HEALTH INFORMATION

The Health Plan generally must track when your health information is shared with others for reasons other than:

- for payment, treatment and health care operations;
- with your permission;
- to family members or friends involved in your care;
- as part of a "limited data set;"
- for certain national security or intelligence reasons or to correctional institutions.

This is referred to as an "accounting of disclosures." You have the right to request a copy of this document.

You may receive information on disclosures of your health information going back for six (6) years from the date of your request. Under certain circumstances your right to an accounting of disclosures may be suspended.

In response to your request, the Health Plan will provide you with the list of disclosures. You may make one (1) request at no cost to you, but the Health Plan may charge a fee for subsequent requests. You will be notified of the fee in advance and have the opportunity to change or revoke your request.

RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE FROM THE HEALTH PLAN UPON REQUEST

You have the right to obtain a paper copy of this Privacy Notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

RIGHT TO RECEIVE NOTIFICATION IF YOUR INFORMATION IS BREACHED

In many instances, you have the right to know if your unsecured information has been lost, stolen, or otherwise seen by people who do not usually have the right to see it. We will contact you if this occurs; no written request from you is required.

CHANGES TO THE INFORMATION IN THIS NOTICE

The Health Plan must abide by the terms of the Privacy Notice currently in effect. This notice took effect on April 14, 2003. However, the Health Plan reserves the right to change the terms of its privacy policies as described in this notice at any time, and to make new provisions effective for all health information that the Health Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Health Plan's privacy policies described in this notice, a revised Privacy Notice will be made available to you.

Complaints

If you believe your privacy rights have been violated, please contact the university Privacy Office, at 502-852-3803 or at privacy@louisville.edu. You may also complain to the Secretary of Health and Human Services.

You will not be retaliated against for filing a complaint.

Contact

For more information on the Health Plan's privacy policies or your rights under HIPAA, contact the university Privacy Office, at 502-852-3803 or at privacy@louisville.edu.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 1-31-2017)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact _____.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

\

3. Employer name		4. Employer Identification Number (EIN)
5. Employer address		6. Employer phone number
7. City	8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above)	12. Email address	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☐ Some employees. Eligible employees are:
- With respect to dependents:
  - ☐ We do offer coverage. Eligible dependents are:
  - ☐ We do not offer coverage.

☐ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

• An employer–sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Combined States L.S., Inc.

Not sponsored or endorsed by the United States Government or any Department or Agency thereof.

(800) 356-LAWS (904) 730-0023 fax

www.uslegalservices.net

Legal Services Plan For

University of Louisville

Membership Enrollment Form

Last name_____ First name_____ Middle initial____

ID number_____ Spouse's name_____

Mailing address_____

City_____ County_____ State_____ Zip Code_____

Telephone #_____ Mobile Telephone #_____

Email address_____

ACTIVE EMPLOYEES:

_____$18.75 Payroll Deduction Signature_____

I agree that this authorization will remain in force and effect until U.S. Legal and Payroll Department has received written notice from the Policyholder of its termination in such time and in such manner as to afford Company and Bank a reasonable opportunity to act on it.

** This agreement shall remain in effect until U.S. Legal has received written notice of cancellation and has had reasonable opportunity to act on it.*

Applicant Signature _____ Date _____

Agent # _____

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete, or misleading information is guilty of a felony of the third degree. I understand that legal services will be provided as outlined in the contract and that I will be responsible for any filing fees, court costs, etc. associated with any action. I authorize for premiums to be collected as indicated above or by any other method I should change to in the future. I understand that the attorney-client relationship is confidential and such relationship is with my assigned attorney and not with U.S. Legal. I represent that to the best of my knowledge, all information above is true and correct and that no person to be insured under the plan is now involved in any litigation, court proceeding, or other matter, which could result in legal action.

UNIVERSITY OF LOUISVILLE®

2016

Benefits Forms

University of Louisville 2016 Benefit Enrollment Form

Last Name	First Name, Middle Initial	Social Security Number	Date of Birth	Gender (check one) ☐ Male ☐ Female
Street Address	**City and State**	**Zip Code**	**Employee ID Number**	**DEPARTMENT**

☐ **I'm a new employee.** My date of hire is:_____ ☐ I'm on a 10-month contract ☐ I'm paying for coverage myself ☐Bi-Weekly ☐Monthly

☐ **I'm a current employee who has experienced a qualifying event** and need to make a change in my coverage (attach support documentation) Eff date:_____

☐ Marriage/QA ☐ Birth/adoption ☐ Spouse/dependent QA has other coverage ☐ Loss of eligibility ☐ Legal separation ☐ Divorce/QA terminates ☐Spouse/dependents coverage ends

Medical-Anthem Blue Cross BlueShield

☐ EPO ☐ PPO ☐ PCA-HRA HIGH ☐ PCA-HRA LOW

☐ CANCEL ☐ Single ☐ Employee & Spouse/QA ☐ Employee & Child(ren) ☐ Family ☐ 2 Employee Family

****

Dental-Humana

☐ CANCEL ☐ Single ☐ Employee & Spouse/QA ☐ Employee & Child(ren) ☐ Family

****

Vision-N.V.A.

☐ CANCEL ☐ Single ☐ Employee & Spouse/QA ☐ Employee & Child(ren) ☐ Family

Spouse/Qualifying Adult and/or dependent(s) to be covered

Name	Social Security #	Date of Birth	Gender	Relationship	Disabled?	Medical	Dental	Vision

I understand, agree and represent: Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. I hereby enroll for benefits for which I am presently eligible or for which I may become eligible under my employer's group contract(s). If any deductions are required for this coverage, I authorize such deductions from my earning. I also agree to review my paycheck to make sure these deductions are correct. I reserve the right to revoke this deduction authorization at any time upon written notice unless I have chosen to use pretax deductions. This document together with any supplements, will form part of any contract and be the basis for any certificate of coverage/certificate of insurance issued.

Employee Signature	Date

If I am applying for health, dental or vision for a qualified adult or the child(ren) of a qualified adult, I understand that the value of health benefits provided to a qualified adult will constitute taxable income. I understand that the University of Louisville defines a qualified adult as someone over 18 years of age, and if a blood relative (or relative by adoption or marriage) must be of the same or younger generation of the employee (as used in KRS 391.010), and must be residing in the employee's household and have done so for a period of at least 12 months, and must be financially interdependent (for example, have joint checking account or joint mortgage) for 12 months or longer, must be unmarried, and must not be eligible for medicare.

University of Louisville 2016 Health Plan Rates

Monthly Rates

FT Active With GHN Discount	Cardinal Care	EPO	PPO	PCA High	PCA Low
Employee Coverage	$ 155.00	$ 96.12	$ 78.58	$ 27.12	$ 25.00
Employee + Spouse/QA	$ 355.00	$ 455.04	$ 416.46	$ 303.24	$ 171.64
Employee + Children	$ 222.00	$ 228.21	$ 196.63	$ 104.01	$ 25.00
Employee + Family	$ 380.00	$ 513.24	$ 460.62	$ 306.24	$ 126.78
Two Employee Family (Rate Per EE)	$ 150.00	$ 95.52	$ 69.21	$ 12.50	$ 12.50

FT Active Without GHN	Cardinal Care	EPO	PPO	PCA High	PCA Low
Employee Coverage	$ 195.00	$ 136.12	$ 118.58	$ 67.12	$ 65.00
Employee + Spouse/QA	$ 395.00	$ 495.04	$ 456.46	$ 343.24	$ 211.64
Employee + Children	$ 262.00	$ 268.21	$ 236.63	$ 144.01	$ 65.00
Employee + Family	$ 420.00	$ 553.24	$ 500.62	$ 346.24	$ 166.78
Two Employee Family (Rate Per EE)	$ 190.00	$ 135.52	$ 109.21	$ 52.50	$ 52.50

PT Active and Retirees With GHN Discount	Cardinal Care	EPO	PPO	PCA High	PCA Low
Employee Coverage	$ 407.15	$ 313.24	$ 294.96	$ 241.18	$ 207.74
Employee + Spouse/QA	$ 830.73	$ 810.91	$ 770.70	$ 652.39	$ 515.33
Employee + Children	$ 656.37	$ 591.43	$ 558.52	$ 461.73	$ 363.93
Employee + Family	$ 1,058.95	$ 1,052.16	$ 997.32	$ 836.00	$ 649.10

PT Active and Retirees Without GHN Discount	Cardinal Care	EPO	PPO	PCA High	PCA Low
Employee Coverage	$ 447.15	$ 353.24	$ 334.96	$ 281.18	$ 247.74
Employee + Spouse/QA	$ 870.73	$ 850.91	$ 810.70	$ 692.39	$ 555.33
Employee + Children	$ 696.37	$ 631.43	$ 598.52	$ 501.73	$ 403.93
Employee + Family	$ 1,098.95	$ 1,092.16	$ 1,037.32	$ 876.00	$ 689.10

10-Month FT Active Employee

FT Active With GHN Discount	Cardinal Care	EPO	PPO	PCA High	PCA Low
Employee Coverage	$ 186.00	$ 115.34	$ 94.30	$ 32.54	$ 30.00
Employee + Spouse/QA	$ 426.00	$ 546.05	$ 499.75	$ 363.89	$ 205.97
Employee + Children	$ 266.40	$ 273.85	$ 235.96	$ 124.81	$ 30.00
Employee + Family	$ 456.00	$ 615.89	$ 552.74	$ 367.49	$ 152.14
Two Employee Family (Rate Per EE	$ 180.00	$ 114.62	$ 83.05	$ 15.00	$ 15.00

FT Active Without GHN	Cardinal Care	EPO	PPO	PCA High	PCA Low
Employee Coverage	$ 234.00	$ 163.34	$ 142.30	$ 80.54	$ 78.00
Employee + Spouse/QA	$ 474.00	$ 594.05	$ 547.75	$ 411.89	$ 253.97
Employee + Children	$ 314.40	$ 321.85	$ 283.96	$ 172.81	$ 78.00
Employee + Family	$ 504.00	$ 663.89	$ 600.74	$ 415.49	$ 200.14
Two Employee Family (Rate Per EE	$ 228.00	$ 162.62	$ 131.05	$ 63.00	$ 63.00

10 Month PT Active Employees

PT Active With GHN Discount	Cardinal Care	EPO	PPO	PCA High	PCA Low
Employee Coverage	$ 488.58	$ 375.89	$ 353.95	$ 289.42	$ 249.29
Employee + Spouse/QA	$ 996.44	$ 973.09	$ 924.84	$ 782.87	$ 618.40
Employee + Children	$ 787.64	$ 709.72	$ 670.22	$ 554.08	$ 436.72
Employee + Family	$ 1,270.74	$ 1,262.59	$ 1,196.78	$ 1,003.20	$ 778.92

PT Active Without GHN Discount	Cardinal Care	EPO	PPO	PCA High	PCA Low
Employee Coverage	$ 536.58	$ 423.89	$ 401.95	$ 337.42	$ 297.29
Employee + Spouse/QA	$ 1,044.88	$ 1,021.09	$ 972.84	$ 830.87	$ 666.40
Employee + Children	$ 835.64	$ 757.72	$ 718.22	$ 602.08	$ 484.72
Employee + Family	$ 1,318.74	$ 1,310.59	$ 1,244.78	$ 1,051.12	$ 826.92

12 Month Active Employees

Dental Full-time/Part-time	Monthly Premiums
Employee Coverage	$24.65
Employee + Spouse/QA	$49.26
Employee + Children	$58.15
Employee + Family	$89.93

10 Month Active Employees

Dental Full-time/Part-time	Monthly Premiums
Employee Coverage	$29.57
Employee + Spouse/QA	$59.11
Employee + Children	$69.78
Employee + Family	$107.92

12 Month Active Employees

Vision Full-time/Part-time	2014 Monthly Premiums
Employee Coverage	$4.28
Employee + Spouse/QA	$7.76
Employee + Children	$8.23
Employee + Family	$11.81

10 Month Active Employees

Vision Full-time/Part-time	Monthly Premiums
Employee Coverage	$5.14
Employee + Spouse/QA	$9.31
Employee + Children	$9.88
Employee + Family	$14.17

University of Louisville
2016 FSA Enrollment Form

You will be making elections for the **January 1, 2016** through **December 31, 2016 Plan Year**. After completing the form, **please sign and return it the Human Resources Department**.

Participant Information – *PLEASE PRINT LEGIBLY*		
First Name		Home Phone ( ) -
Last Name		Work Phone ( ) -
SSN	Employee ID	
Pay Frequency (Select One) ☐ Monthly ☐ BI-Weekly		

PLAN ELECTION DESCRIPTIONS

WAIVER OF MEDICAL COVERAGE CREDIT

If you waive medical coverage, you are eligible to receive an FSA contribution of $175/month in the form of a Waiver Credit from the University. This contribution will automatically go to the Health Care Spending Account unless you elect to have all or part of it deposited into the Dependent Care Spending Account.

☐ **Yes** I am waiving medical coverage and I want all my $175/month to go to a ***Health*** Care Spending account.

OR

☐ **Yes** I am waiving medical coverage and I want all my $175/month to go to ***Dependent*** Care Spending Account.

OR

☐ **NO** I am not waiving medical coverage. I want an FSA in addition to my medical plan. See the section(s) below.

If you are waiving medical coverage, and you want all or part of the dollars to be placed in a Dependent Care Spending Account, receive the Waiver Credit. Please check "Yes" in this section and distribute your Waiver Credit in the FSA section below. If you are not eligible for the Waiver Credit, check no. You will not have any money to spend in the FSA section below.

FLEXIBLE SPENDING ACCOUNT (FSA) CONTRIBUTIONS FROM YOUR PAY

Enter the amount you wish to contribute to each account on an annual basis. Contributions will be withheld from your regular paychecks in equal installments throughout the year on a pre-tax basis. If not contributing, enter "0."

HEALTH CARE SPENDING ACCOUNT
for medical expenses
This is for out-of-pocket medical, dental and vision expenses. You may elect up to a total of $2,550 for the plan year ($150 minimum). If you wish to participate in this account, please enter the amount you wish to elect.

Employee Total Annual Contribution

$_____
Not to exceed $2,550

DEPENDENT CARE SPENDING ACCOUNT
for daycare expenses
This is for day care for your dependents under age 13 and living in your household more than 50% of the year. You may elect up to $5,000 for the plan year ($150 minimum). If you wish to participate in this account, please enter the amount you wish to elect.

Employee Total Annual Contribution

$_____
Not to exceed $5,000

EMPLOYEE AUTHORIZATION

I hereby authorize my employer to deduct from my salary (if applicable), or other compensation, the required contributions for the amounts I have elected above. I agree to comply with the terms and conditions of the plan. I have received and read all the authorizations & acknowledgements provided by Chard Snyder for each plan elected. I also acknowledge the receipt of the HIPAA Privacy Notice provided at open enrollment and/or provided on the Chard Snyder website (www.chard-snyder.com).

Signature Date / /

CLIENT USE ONLY (MUST BE COMPLETED BY HR FOR NEW HIRES)

Employee Effective Date / / 1st Contribution Date / / Initials

EMPLOYEE ACKNOWLEDGEMENT & AUTHORIZATIONS (SEE BELOW)

All sections may not apply. Each section is only applicable if you are electing to participate.

FLEXIBLE SPENDING ACCOUNT – ACKNOWLEDGEMENT & AUTHORIZATION

I understand that:

- I am enrolling in a qualified plan and a description of the plan has been made available to me. I must use the funds I have elected to set aside in my reimbursement account(s) by the end of the Plan Year (as shown above) and submit my claims by the end of the run out period or the funds will be forfeited. If my plan provides a carryover, funds remaining in my FSA reimbursement account will be carried over into the new plan year up to my plan's allowed carryover maximum. Funds remaining above my plan's allowed carryover maximum will be forfeited.
- I cannot change my election once the Plan Year begins; my election(s) must remain in effect for the duration of the Plan Year unless I have a change in family status (marriage, divorce, birth, adoption or death) or in employment status.
- My out-of-pocket expenses must be incurred while I am an eligible participant and during the Plan Year to be considered for reimbursement (the date of service, not the date of invoice, must occur during the Plan Year).
- I cannot itemize and deduct my out-of-pocket expenses again on my IRS Form 1040 for any accounts in which I am enrolled (premiums, health and/or daycare).
- I am required to save all receipts for benefit card purchases in case I should be audited by the IRS.

I hereby authorize my employer to deduct from my salary, or other compensation, the required contributions for the amounts I have elected above. I agree to comply with the terms and conditions of the plan.

PLEASE NOTE: DEPENDENT CARE SPENDING ACCOUNT

Participant elections for the Dependent Care FSA are also limited by the following IRS requirements:

- If married and filing an income tax return jointly, the election must be the lesser of $5,000, the participant's earned income, OR the spouse's earned income for the plan year.
- If married and filing an income tax return separately, the election must be the lesser of $2,500 the participant's earned income, OR the spouse's earned income for the plan year.
- If the participant's spouse is not employed and is disabled, an income equivalent of $200 per month for one dependent or $400 per month for more than one dependent may be used.
- If filing an income tax return as a single parent, the election must be the lesser of $5,000 OR the participant's earned income.

BENNY™ PRE-PAID BENEFITS CARD – ACKNOWLEDGEMENT & AUTHORIZATION:

I understand that:

- I have received, reviewed and understand the procedures of this debit card.
- Benefit card funds are authorized only for the payment of qualified expenses as outlined in my employer's plan document.
- The benefit card may be used only for eligible expenses at the point-of-service, and I may be required to submit a claim form with receipts and/or bills to Chard Snyder to substantiate the expense.
- I cannot itemize and deduct my out-of-pocket expenses again on my IRS Form 1040 for any accounts in which I am enrolled.
- I am required to save all receipts for benefit card purchases in case I should be audited by the IRS.
- If I use my benefit card for ineligible expenses, I will be required to pay back the amount that was not covered by my plan.
- If I do not repay amounts used for ineligible FSA expenses, my employer and/or Chard Snyder has the right to cancel my benefit card and deduct this amount from my salary.
- These FSA funds have not or will not be reimbursed under any other plan coverage.
- Chard Snyder will not be held responsible for processing duplicate claims that I have submitted in error.
- The benefit card may not be accepted at all merchants that accept MasterCard/Visa.
- I must check with my employer to verify the monthly fee, if any, to add to the benefit card.

I understand and agree to the terms and conditions specified on this form and authorize Chard Snyder to complete my request as indicated.

DIRECT DEPOSIT – ACKNOWLEDGEMENT & AUTHORIZATION:

I understand that:

- My financial institution can receive transactions via electronic transfer and the bank information provided can serve this purpose.
- I permit Chard Snyder to initiate electronic credit entries and, if necessary, debit entries to reverse erroneous credits to the above account, and to allow the financial institution indicated above to credit and/or debit the same to such account.
- I will not hold Chard Snyder responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me, my employer or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account.
- Chard Snyder reserves the right to collect a $25 processing fee for transaction returns and reserves the right to periodically change this fee. Chard Snyder is not responsible for any fees that may be incurred and charged to me by my financial institution.
- Direct deposit of my reimbursements shall commence within 4 (four) weeks of receipt of this form.
- My direct deposit may be terminated by any of the following: an online or written cancellation request submitted by me (when allowed by my employer), a failed bank transmittal due to incorrect bank information, cancellation of direct deposit by my employer or in the event that processing fees are incurred and are unpaid for a period of 60 days.

I hereby agree to and understand the information on this form and authorize Chard Snyder to complete my request.

MetLife
Metropolitan Life Insurance Company, New York, NY

ENROLLMENT • CHANGE FORM

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

Name of Group Customer/Employer	Group Customer #	Report #	Sub Code	Branch
University of Louisville	**149183**	**149183**	**0001**	**0001**

Date of Hire (MM/DD/YYYY)	Coverage Effective Date (MM/DD/YYYY)

YOUR ENROLLMENT INFORMATION (To be Completed by the Employee)

Name (First, Middle, Last)	Social Security # – –	☐ Male ☐ Female
Address (Street, City, State, Zip Code)	Date of Birth (MM/DD/YYYY)	

Phone #	Email Address	☐ New Enrollment ☐ Change in Enrollment If due to a Qualifying Event, enter event date (MM/DD/YYYY)

I have read my enrollment materials and I request coverage for the benefits for which I am or may become eligible. I understand that no contributions are required for Basic Life and Basic AD&D. I understand that contributions are required for the benefits I select below.
► If you are enrolling after the initial enrollment period, you must complete a Statement of Health form for all amounts you are requesting.

Term Life Insurance

☒ Basic Life [1]

☐ Supplemental/Optional Life [1]
☐ $20,000 ☐ $30,000 ☐ $40,000 ☐ $50,000 ☐ $60,000 ☐ $70,000 ☐ $80,000 ☐ $90,000 ☐ $100,000 ☐ $110,000 ☐ $130,000
☐ $150,000 ☐ $170,000 ☐ $200,000 ☐ $225,000 ☐ $250,000 ☐ $275,000 ☐ $300,000

☐ Dependent Spouse Life [1,2]
☐ $10,000 ☐ $15,000 ☐ $20,000 ☐ $25,000

☐ Dependent Child Life [2]

Accidental Death & Dismemberment (AD&D) Insurance

☒ Basic AD&D

Dependent Information

If you are applying for coverage for your Spouse and/or Child(ren), please provide the information requested below:

Name of your Spouse (First, Middle, Last) _____ Date of Birth (MM/DD/YYYY) _____ ☐ Male ☐ Female

Name(s) of your Child(ren) (First, Middle, Last) / Date of Birth (MM/DD/YYYY)

_____ _____ ☐ Male ☐ Female
_____ _____ ☐ Male ☐ Female
_____ _____ ☐ Male ☐ Female
_____ _____ ☐ Male ☐ Female

☐ Check here if you need more lines. Provide the additional information on a separate piece of paper and return it with your enrollment form.

[1] Life Insurance may include an Accelerated Benefits Option under which a terminally ill insured can accelerate a portion of his or her life insurance amount. An interest and expense charge may be deducted from the accelerated payment. Receipt of accelerated benefits may affect eligibility for public assistance.
[2] Amounts will be subject to state limits, if applicable.

GEF02-1
ADM

SUBMISSION INSTRUCTIONS
After completion, make a copy for your records and return the original to your Employer.

University of Louisville (New Hire)
EF-XDP101M-NW (04/12)

FRAUD WARNINGS

Before signing this enrollment form, please read the warning for the state where you reside and for the state where the insurance policy under which you are applying for coverage was issued.

Arkansas, District of Columbia, Louisiana, Massachusetts, New Mexico, Ohio, Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Florida: A person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine, Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who files an application containing any false or misleading information is subject to criminal and civil penalties.

New York: [only applies to Accident and Health Benefits (AD&D/Disability/Dental)]: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon and Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Pennsylvania and all other states: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

BENEFICIARY DESIGNATION FOR EMPLOYEE INSURANCE

Note: Dependent insurance is payable to the Employee.
If you have previously designated a beneficiary under this Group Customer's plan, such beneficiary designation will remain in effect. Any MetLife payment upon your death will be paid in accordance with the records of the recordkeeper for such insurance unless you designate a beneficiary below.
I designate the following person(s) as primary beneficiary(ies) for any MetLife payment upon my death.
I understand I have the right to change this designation at any time.

Primary Beneficiary Full Name (Last, First, Middle Initial)	Relationship	Date of Birth (MM/DD/YYYY)	Address (Street, City, State, Zip Code)	Share %
Unless otherwise indicated, payment will be made in equal shares to your surviving Primary Beneficiary(ies).			**TOTAL:**	**100%**

If all of the Primary Beneficiary(ies) die before me, I designate as Contingent Beneficiary(ies):

Contingent Beneficiary Full Name (Last, First, Middle Initial)	Relationship	Date of Birth (MM/DD/YYYY)	Address (Street, City, State, Zip Code)	Share %
Unless otherwise indicated, payment will be made in equal shares to your surviving Contingent Beneficiary(ies).			**TOTAL:**	**100%**

DECLARATIONS AND SIGNATURE

By signing below, I acknowledge:

1. I have read this enrollment form and declare that all information I have given is true and complete to the best of my knowledge and belief.
2. I declare that I am actively at work on the date I am enrolling and, if I am enrolling for any contributory life insurance, that I was actively at work for at least 20 hours during the 7 calendar days preceding my date of enrollment. I understand that if I am not actively at work on the scheduled effective date of insurance, such insurance will not take effect until I return to active work.
3. I understand that, on the date dependent insurance for a person is scheduled to take effect, the dependent must not be confined at home under a physician's care, receiving or applying for disability benefits from any source, or Hospitalized. If the dependent does not meet this requirement on such date, the insurance will take effect on the date the dependent is no longer confined, receiving or applying for disability benefits from any source, or Hospitalized.
4. I understand that if I do not enroll for life coverage during the initial enrollment period, or if I do not enroll for the maximum amount of coverage for which I am eligible, evidence of insurability satisfactory to MetLife may be required to enroll for or increase such coverage after the initial enrollment period has expired. Coverage will not take effect, or it will be limited, until notice is received that MetLife has approved the coverage or increase.
5. I authorize my employer to deduct the required contributions from my earnings for my coverage. This authorization applies to such coverage until I rescind it in writing.
6. I have read the Beneficiary Designation section provided in this enrollment form and I have made a designation if I so choose.
7. I have read the applicable Fraud Warning(s) provided in this enrollment form.

Signature of Employee	Print Name	Date Signed (MM/DD/YYYY)

GEF09-1
DEC

University of Louisville Life Plan Benefits for Active Employees

Explore the coverage that makes it easy to give yourself and your loved ones more security today…and in the future

Basic Term Life and Accidental Death and Dismemberment Insurance (AD&D)

Your employer provides you with Basic Term Life and Accidental Death and Dismemberment insurance coverage in the amount of 2 times your base annual earnings up to a maximum of $200,000.

Supplemental Term Life Insurance Coverage Options for Active Employees

For You	You may elect one of the following options of $20,000, $30,000, $40,000, $50,000, $60,000, $70,000, $80,000, $90,000, $100,000, $110,000, $130,000, $150,000, $170,000, $200,000, $225,000, $250,000, $275,000, or $300,000
For Your Spouse/Qualifying Adult	You may elect one of the following options of $10,000, $15,000, $20,000, $25,000. The coverage amount elected cannot exceed 50% of the employee coverage.
For Your Dependent Children*	
14 days to 1 year old	$500.00
1 year old to 18/26 if a full time student	$10,000

*Child(ren)'s Eligibility: Dependent children ages from 14 days to 18 years old, or 26 years old if a child is a full-time student, are eligible for coverage.

Monthly Costs for Supplemental Term Life Insurance

You have the option to purchase Supplemental Term Life Insurance. Listed below are your monthly rates as well as those for your Spouse/Qualifying Adult (based on your age) and the amount of coverage you want. Rates to cover your child(ren) are also shown.

Age	**Your Monthly Cost Per $1,000 of Coverage**	**Spouse/Qualifying Adult Monthly Cost Per $1,000 of Coverage**
Under 25	$0.054	$0.054
25 - 29	$0.065	$0.065
30 – 34	$0.087	$0.087
35 – 39	$0.098	$0.098
40 – 44	$0.109	$0.109
45 – 49	$0.163	$0.163
50 – 54	$0.250	$0.250
55 – 59	$0.467	$0.467
60 – 64	$0.717	$0.717
65 – 69	$1.379	$1.379
70 +	$2.237	$2.237
Cost for your Child(ren)†	$0.123	

† Covers all eligible children

Note: If you are a bi-weekly paid employee, the total monthly cost of coverage will be divided by 2.

MetLife

Our Privacy Notice

We know that you buy our products and services because you trust us. This notice explains how we protect your privacy and treat your personal information. It applies to current and former customers. "Personal information" as used here means anything we know about you personally.

Plan Sponsors and Group Insurance Contract Holders

This privacy notice is for individuals who apply for or obtain our products and services under an employee benefit plan, or group insurance or annuity contract. In this notice, "you" refers to these individuals.

Protecting Your Information

We take important steps to protect your personal information. We treat it as confidential. We tell our employees to take care in handling it. We limit access to those who need it to perform their jobs. Our outside service providers must also protect it, and use it only to meet our business needs. We also take steps to protect our systems from unauthorized access. We comply with all laws that apply to us.

Collecting Your Information

We typically collect your name, address, age, and other relevant information. We may also collect information about any business you have with us, our affiliates, or other companies. Our affiliates include life, car, and home insurers. They also include a bank, a legal plans company, and securities broker-dealers. In the future, we may also have affiliates in other businesses.

How We Get Your Information

We get your personal information mostly from you. We may also use outside sources to help ensure our records are correct and complete. These sources may include consumer reporting agencies, employers, other financial institutions, adult relatives, and others. These sources may give us reports or share what they know with others. We don't control the accuracy of information outside sources give us. If you want to make any changes to information we receive from others about you, you must contact those sources.

We may ask for medical information. The Authorization that you sign when you request insurance permits these sources to tell us about you. We may also, at our expense:

- Ask for a medical exam
- Ask for blood and urine tests
- Ask health care providers to give us health data, including information about alcohol or drug abuse

We may also ask a consumer reporting agency for a "consumer report" about you (or anyone else to be insured). Consumer reports may tell us about a lot of things, including information about:

- Reputation
- Driving record
- Finances
- Work and work history
- Hobbies and dangerous activities

The information may be kept by the consumer reporting agency and later given to others as permitted by law**.** The agency will give you a copy of the report it provides to us, if you ask the agency and can provide adequate identification. If you write to us and we have asked for a consumer report about you, we will tell you so and give you the name, address and phone number of the consumer reporting agency.

Another source of information is MIB Group, Inc. ("MIB"). It is a non-profit association of life insurance companies. We and our reinsurers may give MIB health or other information about you. If you apply for life or health coverage from another member of MIB, or claim benefits from another member company, MIB will give that company any information that it has about you. If you contact MIB, it will tell you what it knows about you. You have the right to ask MIB to correct its information about you. You may do so by writing to MIB, Inc., 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734, by calling MIB at (866) 692-6901 (TTY (866) 346-3642 for the hearing impaired), or by contacting MIB at www.mib.com.

Using Your Information

We collect your personal information to help us decide if you're eligible for our products or services. We may also need it to verify identities to help deter fraud, money laundering, or other crimes. How we use this information depends on

what products and services you have or want from us. It also depends on what laws apply to those products and services. For example, we may also use your information to:

- administer your products and services
- perform business research
- market new products to you
- comply with applicable laws
- process claims and other transactions
- confirm or correct your information
- help us run our business

Sharing Your Information With Others

We may share your personal information with others with your consent, by agreement, or as permitted or required by law. For example, we may share your information with businesses hired to carry out services for us. We may also share it with our affiliated or unaffiliated business partners through joint marketing agreements. In those situations, we share your information to jointly offer you products and services or have others offer you products and services we endorse or sponsor. Before sharing your information with any affiliate or joint marketing partner for their own marketing purposes, however, we will first notify you and give you an opportunity to opt out.

Other reasons we may share your information include:

- doing what a court, law enforcement, or government agency requires us to do (for example, complying with search warrants or subpoenas)
- telling another company what we know about you if we are selling or merging any part of our business
- giving information to a governmental agency so it can decide if you are eligible for public benefits
- giving your information to someone with a legal interest in your assets (for example, a creditor with a lien on your account)
- giving your information to your health care provider
- having a peer review organization evaluate your information, if you have health coverage with us
- those listed in our "Using Your Information" section above

HIPAA

We will not share your health information with any other company – even one of our affiliates – for their own marketing purposes. If you have dental, long term care, or medical insurance from us, the Health Insurance Portability and Accountability Act ("HIPAA") may further limit how we may use and share your information.

Accessing and Correcting Your Information

You may ask us for a copy of the personal information we have about you. Generally, we will provide it as long as it is reasonably retrievable and within our control. You must make your request in writing listing the account or policy numbers with the information you want to access. For legal reasons, we may not show you anything we learned as part of a claim or lawsuit, unless required by law.

If you tell us that what we know about you is incorrect, we will review it. If we agree, we will update our records. Otherwise, you may dispute our findings in writing, and we will include your statement whenever we give your disputed information to anyone outside MetLife.

Questions

We want you to understand how we protect your privacy. If you have any questions about this notice, please contact us. When you write, include your name, address, and policy or account number.

Send privacy questions to:

MetLife Privacy Office, P. O. Box 489, Warwick, RI 02887-9954
privacy@metlife.com

We may revise this privacy notice. If we make any material changes, we will notify you as required by law. We provide this privacy notice to you on behalf of these MetLife companies:

Metropolitan Life Insurance Company
General American Life Insurance Company
SafeGuard Life Insurance Company
MetLife Insurance Company of Connecticut
SafeGuard Health Plans Inc.