SPENCER COUNTY FISCAL COURT

Employee Benefits Guide

July 1, 2022 through June 30, 2023

Employee benefit plans and policies may be changed at the sole discretion of the company at any time. This document is an outline of the coverage proposed by the carrier(s), the information in this document is presented for illustrative purposes based on information provided by your company. The text contained in this Guide was taken from various summary plan descriptions and benefit information. It does not include all the terms, coverages, exclusions, limitations, and conditions of the actual contract language. The policies themselves must be read for those details. The intent of this document is to provide you with general information about your employee benefit plans. It does not necessarily address all the specific issues which may be applicable to you. While every effort was taken to accurately report your benefits, discrepancies, or errors are always possible. It should not be construed as, nor is it intended to provide legal advice. In case of discrepancy between this booklet and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Guide, contact Human Resources.

GENERAL INFORMATION

Employee Eligibility

All employees working 30 hours or more per week are eligible for benefits.

NEW HIRE BENEFITS BEGIN:	first of month following 30 days from your full-time date of hire
ANNUAL OPEN ENROLLMENT:	Elections completed in June Benefits effective: July 1

How to Enroll

NEW HIRES:	To enroll you must complete your enrollment form prior to the end of the new hire waiting period. The elections you make will be in effect through 6/30. You cannot change your election without a Qualifying Life Event.
ANNUAL OPEN ENROLLMENT:	Complete an annual election form to confirm no changes, or to request that you are contacted in order to review coverage and complete new enrollment forms to make changes.

Pre-Tax Premium Plan & Qualifying Life Events

In accordance with your rights under the Plan, if you elect to receive benefit coverage under the Plan, you understand that an amount equal to the annual contributions for the coverage you elect, divided by the number of pay periods in the Plan Year, will be deducted on a pretax basis from each paycheck to pay for elected coverage. You cannot change or revoke this agreement as of any date prior to the next Plan Year, unless you have a Qualifying Life Event. Qualifying Life Events include, for example:

- Birth or Adoption
- Change in child's dependent status
- Marriage or Divorce
- Change in employment status
- Death of Spouse/Dependent
- Change in coverage under another employer-sponsored plan

If any events other than these listed occur, check with your HR department to see if you may make changes during the year. Some examples of events that do not allow you to change your election are:

- The benefit cost is too high/payroll deduction was more than anticipated
- You do not like the coverage

MEDICAL INSURANCE

Employees have the option of three medical plans. The following chart compares the three current benefits.

	ANTHEM BCBS		
In-Network Services	**Alternate Plan**	**Core Plan**	**Buy-up Plan**
Plan Name	2022 Option A28 Rx T1	2022 Option A22 Rx T1	2022 Option A4 Rx T1
Preventive Care	Covered at 100%	Covered at 100%	Covered at 100%
Physician Visit	$20 Enhanced Primary $30 primary care $75 specialist	$10 Enhanced Primary $20 primary care $50 specialist	$10 Enhanced Primary $20 primary care $50 specialist
Calendar Year Deductible	$5,000 Individual $10,000 Family	$2,500 Individual $5,000 Family	$500 Individual $1,500 Family
Hospitalization	0% after deductible	20% after deductible	20% after deductible
Outpatient	0% after deductible	20% after deductible	20% after deductible
Urgent Care	$30 copay	$20 copay	$20 copay
Emergency Room	0% after $300 copay	20% after $300 copay	20% after $300 copay
Durable Medical Equipment	50% after deductible	50% after deductible	50% after deductible
Out-of-Pocket Max (all services apply)	$7,000 Individual $14,000 Family	$6,500 Individual $13,000 Family	$4,000 Individual $8,000 Family
Prescription Drugs	**Level 1*** $10 Tier 1 $35 Tier 2 $75 Tier 3 25% up to $350 Tier 4 **Level 2*** $20 Tier 1 $45 Tier 2 $85 Tier 3 25% up to $450 Tier 4	**Level 1*** $10 Tier 1 $35 Tier 2 $75 Tier 3 25% up to $350 Tier 4 **Level 2*** $20 Tier 1 $45 Tier 2 $85 Tier 3 25% up to $450 Tier 4	**Level 1*** $10 Tier 1 $35 Tier 2 $75 Tier 3 25% up to $350 Tier 4 **Level 2*** $20 Tier 1 $45 Tier 2 $85 Tier 3 25% up to $450 Tier 4
Medicare Part D	Creditable	Creditable	Creditable

***Level 1 includes CVS, Kmart, Target, Kroger, Walmart, Costco and Meijer. Level 2 pharmacies are Walgreens and Rite-Aid. Independent pharmacies may vary. For a more detailed explanation of benefits, please refer to the Summary of Benefits and Coverage (SBC).**

Your Cost for this Year

EMPLOYEE BI-WEEKLY DEDUCTIONS			
	Alternate Plan	**Core Plan**	**Buy-up Plan**
Employee Only	$24.69	$50.52	$100.41
Employee/Spouse	$400.64	$454.90	$559.66
Employee/Child(ren)	$298.11	$344.61	$434.87
Family	$776.59	$859.27	$1,018.91

HEALTH REIMBURSEMENT ARRANGEMENT (HRA) – FEBCO/USADMIN

For employees on the Anthem BCBS medical insurance, Spencer County Fiscal Court will contribute $1,000 per employee per plan year to fund your account. HRA funds can be used to reimburse qualified healthcare expenses.

The $1,000 annual contribution will available as of July 1st.

If you are a new hire, you are eligible to enroll in these benefits the first of the month following 30 days from your date of hire. Benefits for new hires will be pro-rated based on the number of months eligible.

If you are waiving the medical coverage, you must sign an affidavit to acknowledge that you have other qualified group coverage in order to be eligible and enrolled in the HRA.

Meet your new health champion

Enhanced Personal Health Care doctors go above and beyond for you

Whether you go to the doctor rarely or often, you should find a primary care physician (PCP) you like and trust. Checking out Enhanced Personal Health Care (EPHC) doctors is a great way to start your search. Enhanced Personal Health Care professionals (including primary care doctors and other medical staff) have agreed to provide high-quality care and focus on your whole health — not just your symptoms. In fact, Anthem members who choose an EPHC doctor are happier with their doctors and their overall health.*

Your Enhanced Personal Health Care doctor has agreed to go above and beyond and:

- Focus on preventing illnesses and helping you get healthy faster and stay healthy longer.
- Coordinate your overall health care to avoid any gaps in care. This entails things like setting up appointments with specialists to ensuring you're following your prescription plan and getting the right tests and screenings regularly.
- Help you avoid unnecessary medical services and tests, saving you money and reducing stress.
- Use specialized health information to help them better coordinate and manage your care.
- Be available to you 24/7 through extended office hours, after-hours call coverage and sometimes even online.
- Spend extra time with you to get to know you and your health goals.
- Contact you when you're due for a preventive exam or screening.

Choose the kind of professional who's right for you

- **Family practice/general practice** — These doctors offer a wide range of care, from check-ups to pregnancy care. This type of doctor might be a good choice if you want to keep all of your family members under the same doctor's care. A doctor who treats everyone in a family can sometimes get a better view of each person's health.
- **Internal medicine** — Internal medicine doctors mainly treat adults and offer a range of care, including preventive care. But they may have special knowledge about certain health problems. So if you have a long-term health problem, an internist who also focuses on that particular problem may be a good fit for you.
- **Pediatricians** care for infants, children, and adolescents.
- **Nurse practitioners and physician assistants** aren't doctors, but they've had lots of training. They can do many of the same things that doctors do.

Ready to find your Enhanced Personal Health Care doctor?

1. Log in or register at **anthem.com**.
2. Under **Find a Doctor**, enter your location and search distance. Be sure to select the boxes *for Able to serve as primary care physician* (PCP) and *Enhanced Personal Health Care*.
3. Choose **Search** and you'll see a list of available doctors near you.

* AEPHC Patient Experience Survey Results. In 2015, 2,751 EPHC patient interviews were conducted across four distinct EPHC patient populations. 746 interviews for non-EPHC Group. Analyses conducted across patient experience domains to identify performance of EPHC providers over time, and, comparative performance to non-EPHC providers.

Convenience or savings? No need to choose.

You get both with Rx Choice Tiered Network.

With your plan, you have lots of choices about where to get your prescription medicines. And with the Rx Choice Tiered Network, you can choose a pharmacy that saves you money.

Your pharmacy network offers two levels of coverage:

$ Level 1

These are our preferred pharmacies, where your copay or share of the prescription cost is lower. There are more than 25,000* Level 1 pharmacies across the country, including well known chains like:

- CVS
- Target
- Costco
- Kroger
- Meijer
- Sam's Club
- Walmart

$$ Level 2

You'll pay a little more for your prescriptions at a Level 2 pharmacy. There are 40,000* of these around the country, including:

- Walgreens
- Rite Aid

It's easy to find a pharmacy in the Rx Choice Tiered Network

- Visit anthem.com, choose **Manage Your Prescriptions** and log on.
- On the *Pharmacy* page, choose **Find a Pharmacy**.
- Enter your ZIP code and how far you want to search to find pharmacies near you.

Questions?

Call the Pharmacy Member Services number on the back of your plan ID card.

* IngenioRx data, 2019.

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Anthem

Focus on your well-being and earn rewards up to $200

The more activities you complete, the greater your reward.

Your whole health matters, and we want to reward you for taking care of it. The Wellbeing Solutions program, sponsored by your employer, connects you with easy-to-use digital health and wellness tools that can help you stay your best. When you complete any of the activities listed below, you'll earn rewards to put toward electronic gift cards for select retailers. You choose the activities you'd like to complete to receive the maximum of $200 in rewards. Don't wait, use your Sydney Health app or Anthem.com to learn more.

Activity type	Activities	Amount
Preventive care measures How you earn: Receive your reward when claims are processed	Complete a colorectal cancer screening (45 years and older)	$25
	Complete a routine mammogram (women 40 to 74)	$25
	Complete an annual preventive wellness exam or well woman exam with your doctor	$25
	Get an annual cholesterol test[1]	$20
	Get an annual flu shot	$20
	Have an annual eye exam[2]	$25
Condition management programs **How you earn:** Reach certain benchmarks or complete a program	ConditionCare program: Work one-on-one with your health coach for a chronic condition and earn rewards for participating in and completing the program[3]	Up $50 ($20 participation/$30 completion)
	Future Moms program: Moms-to-be can receive support from a registered nurse and earn rewards for completing initial, interim, and postpartum assessments[4]	Up to $40 ($20 initial/$10 interim/$10 postpartum assessments)
	Wellbeing Coach Telephonic – Weight Management Program: Receive one-on-one support and lifestyle coaching for weight management. Complete your goal to earn a reward[5]	$25
	Wellbeing Coach Telephonic – Tobacco Cessation Program: Receive one-on-one support and lifestyle coaching for tobacco cessation. Complete your goal to earn a reward[6]	$25
Digital Wellness activities How you earn: Complete activities in the Sydney Health℠ app or on anthem.com	Complete action plans around eating healthy, weight management, physical activity, and more	Up to $25 ($5 per action plan)
	Complete a health assessment and receive tailored health recommendations	$20
	Complete Well-being Coach Digital daily mission check-ins[7]	Up to $20 ($4 per milestone)
	Connect a fitness or lifestyle device	$5
	Log in to your Anthem account	$5
	Track your steps	Up to $60 ($2 per 50,000 steps tracked)
	Update your contact information	$10

Well-being Coach can help you meet your goals

Well-being Coach offers multiple options to help you meet your health goals. Our digital coaching app offers personalized 24/7 support on the go. Well-being Coach combines smart technology and proven behavioral therapy techniques to help you maintain a healthy weight, quit tobacco, and improve your nutrition, activity, mindfulness and sleep. Well-being Coach is powered by Lark and accessible from the Sydney Health app.

If you prefer a helping hand and would like additional support meeting your health goals for high-risk weight management and tobacco cessation, Well-being Coach gives you access to a certified health coach by phone. You and your health coach will identify healthy habits and develop custom action plans to achieve your health goals. No matter how you connect, you can earn rewards with Well-being Coach.

How to redeem your rewards

When you're ready to redeem your rewards, open the Sydney Health app or go to anthem.com. Then go to *My Health Dashboard*, select Redeem Rewards, and use your rewards credit toward an electronic gift card.

You choose from popular retailers including MasterCard, Amazon, Bed Bath & Beyond, Gap (all brands), Staples, Target, The Home Depot, and TJ Maxx. The minimum gift card amount is set by each individual retailer.

Open the Sydney Health app or log into anthem.com anytime to explore the electronic gift card options available to you.

If you'd like more information about any of the Wellbeing Solutions activities, call the Member Services number on the back of your ID card

1 Annual cholesterol test eligibility: men 35 years and older, women 40 years and older with a full cholesterol (Lipid) panel
2 Routine Annual eye exam reward is available if employer provides vision coverage through Anthem.
3 Adult members identified as moderate or high risk are eligible for ConditionCare and may receive a reward for participation in 1 of 5 ConditionCare programs and completion for 1 of 5 ConditionCare programs: (Chronic Obstructive Pulmonary Disease (COPD), Coronary Artery Disease (CAD), Asthma, Diabetes, and Congestive Heart Failure (CHF).
4 Future Moms assessments completion dates: Initial assessment must be completed by day 97; Interim assessment must be completed by 1 day prior to delivery; Postpartum Assessment must be completed by 56 days after delivery.
5 Well-being Coach Weight Management program (telephonic) is available for members who are identified as high risk based on a BMI of 30 or higher.
6 Well-being Coach Tobacco Cessation program (telephonic) is available for members who are identified as high risk based on any tobacco usage.
7 Members may earn rewards for completing quarterly Well-being Coach Digital milestones while logging daily mission check-in activities on the digital coaching app: daily Mission check-ins: 1st check-in: $4, next 15 check-ins during 1sr quarter: $4, 25 check-ins for quarters 2-4: $4 each quarter) The digital coaching app download is available using Sydney Health or anthem.com. Well-being Coach Digital is provided by Lark Health.

All preventive care activities are claims-based. Medical waivers apply to all claim-based activities.

Rewards eligibility applies to only employees and their spouse/domestic partner. Members must be active on the plan and activity must take place during the plan effective year. It may take a little time once you complete a wellness activity before you see the reward amount in your account.

Subscriber and spouse/domestic partner may earn rewards when eligible activities are completed and, in some instances, are verified by an Anthem claim. Anthem claims are required for claims-based activity rewards and may take up to 60 days to adjudicate.

Product availability may vary. The reward amount redeemed may be considered income to you and/or your spouse/domestic partner and subject to state and federal taxes in the tax year it is paid. You and/or your spouse/domestic partner should consult a tax expert with any question regarding tax obligations.

The list of retailers available for electronic gift card rewards redemption is subject to change. Open the Sydney Health app or log on to anthem.com or to explore the electronic gift card options available to you.

Employee Assistance Program
Service Summary
KACo

Anthem

Available 24/7, 365 days a year

Everything you share is confidential.*

When you need help meeting life's challenges, the Anthem Blue Cross and Blue Shield Employee Assistance Program (EAP) is here for you and your household members. Check out some of the services we offer — at no cost to you:

Counseling

- Up to 3 visits per issue
- Face-to-face counseling or online visits via LiveHealth Online
- Can call EAP or use the online Member Center to initiate services

Legal consultation

- 30-minute phone or in-person meeting
- Discounted fees to retain a lawyer
- Online resources, including free legal forms, seminars and a library of articles

Financial consultation

- Phone meeting with financial professionals
- Consultation available during regular business hours — no time limits or appointments needed
- Online resources, including articles, calculators and budgeting tools

ID recovery

- Identity theft risk level checked by specialists
- Help with reporting to consumer credit agencies
- Assistance filling out paperwork and negotiating with creditors

Dependent care and daily living resources

- Information available on child care, adoption, summer camps, college placement, elder care and assisted living through the EAP website
- For help with everyday needs, like pet sitting, relocation resources and more

Other anthemEAP.com resources

- Well-being articles, podcasts and monthly webinars
- Self-assessment tools for depression, anxiety, relationships, alcohol use, eating habits and more

Crisis consultation

- Toll-free number for emergencies
- Round-the-clock help available

On-demand digital resources

- @AnthemEAP Twitter tips for staying healthy and balancing work-life needs
- The WellPost blog at anthemEAP.com, featuring Health & Wellness topics written by experts in the field

Need help? Give EAP a try today.

Call us at **800-865-1044**. Or go to **anthemEAP.com** and enter your company code: **KACo**.

* In accordance with federal and state law, and professional ethical standards. This document is for general informational purposes. Check with your employer for specific information about benefits, limitations and exclusions.

Language Access Services – (TTY/TDD: 711)
Spanish – Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda.
Chinese – 您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。

Anthem Blue Cross and Blue Shield complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

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VISION - ANTHEM BCBS/KACO – INCLUDED WITH MEDICAL COVERAGE

In-Network Services		Frequency
Eye Exam	$20 copay	Once per 12 months
Lenses	$20 copay	Once per 12 months
Frame Allowance	up to $130 retail value	Once per 24 months
Contact Allowance	Up to $130 in lieu of frames	Once per 12 months

ADDITIONAL VOLUNTARY VISION - AVESIS

In-Network Services	Vision Care Plan Benefits	Frequency
Eye Exam	$20 copay	Once per 12 months
Lenses	$20 copay Standard Lens Package	Once per 12 months
Frame Allowance	Up to $120 retail frame allowance	Once per 24 months
Contact Allowance	Up to $120 in lieu of frames	Once per 12 months
Carrier Information	Customer Service: 1-800-828-9341 www.avesis.com Visit website or contact customer service to receive a listing of providers in your area	

Your Cost for this Year

EMPLOYEE BI-WEEKLY DEDUCTIONS				
	Employee Only	**Employee & Spouse**	**Employee & Children**	**Employee & Family**
VISION	$3.78	$6.32	$6.47	$10.23

DENTAL – DELTA DENTAL

Amount You Pay	See a PPO participating dentist	See a Delta Dental Premier or Non-participating dentist
Deductible Applies to basic and major services only	$50 Individual / $150 Family	$50 Individual / $150 Family
Preventive Services	0% (deductible does not apply)	0% (deductible does not apply)
Basic Services - including Endodontic & Periodontal Services	20% after deductible	20% after deductible
Major Services	50% after deductible	50% after deductible
Annual Maximum	$1,000 per calendar year	
Orthodontics	50% up to a $1,000 lifetime maximum for dependents to age 19	
Carrier Information	Website: www.deltadentalky.com	
Additional Benefits	-Composite Fillings on Posterior Teeth -Implants	
Waiting Period	12 month waiting period for Major Services and Orthodontics (Waiting period is waived for those currently enrolled on dental)	

Your Cost for this Year

EMPLOYEE BI-WEEKLY DEDUCTIONS				
	Employee Only	**Employee & Spouse**	**Employee & Children**	**Employee & Family**
DENTAL	$13.16	$28.30	$38.57	$53.70

LIFE/AD&D INSURANCE BENEFITS – DEARBORN

Spencer County Fiscal Court provides full-time employees with $15,000 group life and accidental death and dismemberment (AD&D) insurance and pays the full cost of this benefit. Benefits reduce by 35% at age 65, by 55% at age 70 and by 70% at age 75.

VOLUNTARY LIFE INSURANCE – DEARBORN

Employees who want to supplement their group life insurance benefits may purchase additional coverage. When you enroll yourself and/or your dependents in this benefit, you pay the full cost through bi-weekly payroll deductions.

A onetime open enrollment is available to new hires in their waiting period to elect up to the guarantee issue amount. Once this new hire eligibility period has expired*, you must complete a health statement to apply or increase your coverage and the coverage must be approved by underwriting

Benefit Description	
Voluntary Supplemental Life*	**Employee:** increments of $10,000 up to $200,000; but not to exceed 5X salary **New Hire Guarantee Issue Amount at Initial Eligibility*:** $50,000 **You must enroll in additional Life/AD&D for yourself in order to elect for your dependents.** **Spouse:** increments of $10,000 up to $100,000; but cannot exceed 100% of employee's coverage amount. **New Hire Spouse Guarantee Issue Amount at Initial Eligibility*:** $10,000 *Rates are based on your age, not your spouse's **Child(ren):** Birth to 6 months: $100 6 months to age 19 (23 if full time student): $10,000 You cannot be insured as both an employee and a dependent. Your child cannot be insured by more than one employee Benefits reduce by 35% at age 65, by 55% at age 70 and by 70% at age 75. The cost of this insurance is paid by you.

* Any purchase amount which does not take place within 31 days of your new hire eligibility effective date will be subject to underwriting approval; including adding coverage for you or a dependent and increasing coverage amounts from current benefits for you or a dependent.

See next page for Employee & Spouse rates: rates are based on your age, not your spouse's age.

Bi-Weekly Premium – Dependent Child Coverage	
$10,000	$0.92

Supplemental Life
PREMIUM RATE GRID

Dearborn National

Spencer County Fiscal Court

Eligibility

You are eligible to enroll if you work the minimum number of hours per week by your employer, and you have satisfied any waiting period.

Supplemental Life

Employee Benefit: **$10,000 to $200,000 in $10,000 increments.**

Spouse Benefit: **$10,000 to $100,000 in $10,000 increments. (not to exceed 100% of the employee benefit)**

Note: Spouse may not have coverage unless the employee has coverage.

Guarantee Issue*

Employee	**$50,000**
Spouse	**$10,000**

*Assumes 37% participation

Child Coverage

Birth to 14 days:	**$100**
15 days to 6 months:	**$100**
6 months to age 19:	**$10,000**
(Maximum Student Age 23:)	

Benefits reduce by 35% of the original amount at age 65; and further reduce by: 55% of the original amount at age 70; and 70% of the original amount at age 75.

Employee Supplemental Life

Monthly rates per $1,000

Age	Rates
Under 20	$0.080
20-24	$0.080
25-29	$0.080
30-34	$0.090
35-39	$0.130
40-44	$0.200
45-49	$0.330
50-54	$0.490
55-59	$0.800
60-64	$1.280
65-69	$2.030
70-74	$3.330
75+	*

* Please contact your HR Dept.

Dependent Life (Children)

Monthly Premium per Family Life

$10,000 $2.00

Supplemental Life

Premium Cost (Based on 26 payroll deductions per year)

		ATTAINED AGE											
Benefit Amount		<20	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74
$10,000		$0.37	$0.37	$0.37	$0.42	$0.60	$0.92	$1.52	$2.26	$3.69	$5.91	$9.37	$15.37
$20,000		$0.74	$0.74	$0.74	$0.83	$1.20	$1.85	$3.05	$4.52	$7.38	$11.82	$18.74	$30.74
$30,000		$1.11	$1.11	$1.11	$1.25	$1.80	$2.77	$4.57	$6.78	$11.08	$17.72	$28.11	$46.11
$40,000		$1.48	$1.48	$1.48	$1.66	$2.40	$3.69	$6.09	$9.05	$14.77	$23.63	$37.48	$61.48
$50,000		$1.85	$1.85	$1.85	$2.08	$3.00	$4.62	$7.62	$11.31	$18.46	$29.54	$46.85	$76.85
$60,000		$2.22	$2.22	$2.22	$2.49	$3.60	$5.54	$9.14	$13.57	$22.15	$35.45	$56.22	$92.22
$70,000		$2.58	$2.58	$2.58	$2.91	$4.20	$6.46	$10.66	$15.83	$25.85	$41.35	$65.58	$107.58
$80,000		$2.95	$2.95	$2.95	$3.32	$4.80	$7.38	$12.18	$18.09	$29.54	$47.26	$74.95	$122.95
$90,000		$3.32	$3.32	$3.32	$3.74	$5.40	$8.31	$13.71	$20.35	$33.23	$53.17	$84.32	$138.32
$100,000		$3.69	$3.69	$3.69	$4.15	$6.00	$9.23	$15.23	$22.62	$36.92	$59.08	$93.69	$153.69
$150,000		$5.54	$5.54	$5.54	$6.23	$9.00	$13.85	$22.85	$33.92	$55.38	$88.62	$140.54	$230.54
$200,000		$7.38	$7.38	$7.38	$8.31	$12.00	$18.46	$30.46	$45.23	$73.85	$118.15	$187.38	$307.38

SUMMARY OF BENEFITS FOR 2022/2023 - Rates are BI-WEEKLY

-Portable-You can take the plan with you if you leave your job
-No Lifetime Limit-policy won't terminate based on number or $ amount of claims paid

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1) ACCIDENT COVERAGE (OPTION 4):

COVERAGE FOR ACCIDENTS ONLY – 24 HOURS/DAY, 7 DAYS/WEEK, ON OR OFF THE JOB INJURIES
- Accidental Death Benefit for Employee/Spouse - $50,000, $15,000 for each Child; Accidental Dismemberment - $300 - $50,000
- Annual Wellness - $60 (One per calendar year, available on effective date of policy)
- Accident Emergency Treatment - Every 24 Hrs: -ER w/X-ray: $200, w/out X-ray: $170, Office or facility (other than ER) w/ X-ray: $150 w/out X-ray: $120
- Initial Hospitalization - $1,500; Initial ICU Confinement - $2,500; Daily Hospital confinement - $300/Day for 365 Days; Add'l $500/Day-ICU- Days 1-15
- Pays out for Burns/Cuts/Breaks/Fractures/Surgical procedures/Eye injuries etc. - $40 - $13,000; Diagnostic exam-MRI/CT Scan/EEG etc. - $250 (1 per year)
- Follow-up visits - $40, 6 per Covered Accident; Physical Therapy - $40, 10 per Covered Accident; Rehab from the Hospital - $200/Day
- Appliances - $25 - $350; Prosthesis - $1,000 – once per person per covered accident; Prosthesis Repair - $1,000 – once per person per lifetime
- Blood/Plasma/Platelets - $300; Ambulance - $250 Ground, $1,875 Air; Transportation - $700/Round Trip; Family Lodging - $150/ Night
- Family Support Benefit - $20 per day (up to 30 days) per covered accident
- Organized Sporting Activity Benefit – Additional 25% of the benefits payable, limited to $1,000 per policy per calendar year

RATES: OPTION 4: AGE: 18-75: Employee $14.28 E+Spouse $19.02 E+Children $22.14 Family $27.90

1-A) ADDITIONAL ACCIDENTAL DEATH BENEFIT RIDER (CAN BE ADDED TO ACCIDENT):

-ADDS $35,000 Employee/Spouse/$7,000 Child -ACCIDENTAL DEATH BENEFIT

ADR RATES: AGE: 18-75 Employee $1.98 E+Spouse $2.76 E+Children $2.22 Family $3.12

1-B) AFLAC PLUS RIDER: (CAN BE ADDED TO ACCIDENT)

***TIER ONE CRITICAL ILLNESS EVENT:* - $5,000 ON INITIAL DIAGNOSIS, $2,500 ON NEXT DIAGNOSIS OF:**

HEART ATTACK, STROKE, COMA, PARALYSIS, TYPE 1 DIABETES,TRAUMATIC BRAIN INJURY, ADV ALZHEIMER'S, ADV PARKINSON'S, ALS, LOSS OF INDEPENDENCE, SUSTAINED MS, PERMANENT LOSS OF SIGHT, HEARING, SPEECH, SUDDEN CARDIAC ARREST

***TIER TWO CRITICAL ILLNESS EVENT:* - $1,250 ON DIAGNOSIS OF:**

ENCEPHALITIS, BACTERIAL MENINGITIS, LYME DISEASE, SICKLE CELL ANEMIA, CEREBRAL PALSY, NECROTIZING FASCIITIS, OSTEOMYELITIS, SYSTEMIC LUPUS, CYSTIC FIBROSIS

***CORONARY ARTERY BYPASS GRAFT SURGERY:* - $1,250 ON DIAGNOSIS/PROCEDURE**

***TIER THREE CRITICAL ILLNESS EVENT:* - PAYS THE HIGHEST APPLICABLE BENEFIT AMOUNT LISTED PER PERIOD OF HOSPITAL CONFINEMENT OR PERIOD OF INTENSIVE CARE UNIT CONFINEMENT UPON A COVERED PERSON'S ONSET DATE OF THE FOLLOWING:**

1) **HUMAN CORONAVIRUS**
2) **BIRD FLU/H5N1**
3) **INFLUENZA**
4) **PNEUMONIA**
5) **EBOLA**

BENEFIT AMOUNTS:

HOSPITAL CONFINEMENT 4-9 DAYS - $1,250
HOSPITAL CONFINEMENT 10 DAYS OR MORE - $3,125
INTENSIVE CARE UNIT CONFINEMENT - $5,000

MAXIMUM AMOUNT PAYABLE PER 180 DAYS IS $5,000

AGE	RATES:						
18-29	Employee	$1.44	E+Spouse $2.70	E+Children	$2.88	Family $3.48
30-39	Employee	$2.04	E+Spouse $4.02	E+Children	$3.12	Family $4.50
40-49	Employee	$3.48	E+Spouse $6.60	E+Children	$4.20	Family $6.78
50-70	Employee	$5.94	E+Spouse $11.34	E+Children	$6.12	Family $11.40

SUMMARY OF BENEFITS FOR 2022/2023 Rates are BI-WEEKLY

2) CANCER PROTECTION ASSURANCE: OPTION 2 - DEP. CHILDREN UNDER AGE 26 – COVERED AT NO ADDITIONAL COST

- First Occurrence - $4,000, Child $8,000; Annual Wellness - $75
- Radiation Therapy, Chemo, Immunotherapy or Experimental Chemo- Self Administered $250 /month, Physician Administered $1,200/month
- Hormonal Therapy - $25 Once/month; Topical Chemo $150 Once/month; Antinausea - $100 Once/month
- Stem Cell Transplant/Bone Marrow Transplant - $7,000, $7000 Lifetime Max; Donor benefit: $$100 Stem Cell Donation, or $750 for Bone Marrow Donation
- Surgical Benefit - $100-$3,400; Skin Cancer Surgery - $35-$400;
- Hospital Confinement – Days 1-30 $200/day; Child $250/day; After Day 31 $400/day; Child $500/day
- Extended Care - $100 /day, 30 day/year limit; Home Health Care - $100/day, 30 day/year limit
- Hospice - $1,000 First day, $50/day thereafter; $12,000 Lifetime Max per Covered Person
- Nursing Services - $100/day; No Lifetime Max
- Surgical Prosthesis - $2,000; Lifetime Max $4,000 per Covered Person; Nonsurgical Prosthesis - $175 per occurrence; Lifetime Max $350 per covered Person
- Reconstructive Surgery - $220-$2,000
- Ambulance - $250 Ground; $2,000 Air
- Transportation (When treatment is over 50 miles from residence) $.40/mile; max $1,200/round trip; Lodging - $65/day; limited to 90 days/year

RATES: AGE 18-75: Employee $15.46 E+Spouse $26.60 E+Children $15.46 Family $26.60

3) HOSPITAL CHOICE: COVERAGE FOR INJURY OR ILLNESS

- First day confinement for ILLNESS OR INJURY - $1,000

-$1,000 On First day confinement for ILLNESS OR INJURY, payable once per calendar year, per covered person
-$100 per day for Rehab from hospital, Limited to 15 days per confinement, 30 days per calendar year
-$100 Hospital Emergency Room, Limited to 2 payments per calendar year, per covered person
-$100 Hospital Short Stay, Limited to 2 payments per calendar year, per policy

AGE RATES: OPTION: $1,000

18-49	**Employee**	**$11.64**	**E+Spouse**	**$16.50**	**E+Children**	**$14.76**	**Family**	**$17.52**
50-59	**Employee**	**$11.88**	**E+Spouse**	**$17.46**	**E+Children**	**$15.00**	**Family**	**$17.70**
60-75	**Employee**	**$12.18**	**E+Spouse**	**$18.66**	**E+Children**	**$15.24**	**Family**	**$18.84**

3-A) OPTIONAL -EXTENDED BENEFIT RIDER: (CAN BE ADDED TO HOSPITAL CHOICE ABOVE)

- Physician visit $25, Employee only coverage limited to 3 visits per cal yr, Employee/Spouse/Family, limited to 6 visits per calendar year
- Medical Diagnostic/Imaging $150, limited to 2 exams per covered person, per calendar year
- Ambulance $200 Ground, $2,000 Air, limited to 2 trips per calendar year, per covered person

AGE RATES: OPTION: EBR

18-49	**Employee**	**$5.04**	**E+Spouse**	**$10.56**	**E+Children**	**$9.96**	**Family**	**$12.78**
50-59	**Employee**	**$5.70**	**E+Spouse**	**$11.82**	**E+Children**	**$10.20**	**Family**	**$13.02**
60-75	**Employee**	**$5.76**	**E+Spouse**	**$11.94**	**E+Children**	**$10.44**	**Family**	**$13.56**

3-B) OPTIONAL –HOSPITAL STAY AND SURGICAL CARE RIDER: (CAN BE ADDED TO HOSPITAL CHOICE ABOVE)

-Surgical Benefit $50 to $1,000, limited to one payment per 24-hour period, per covered person
-Invasive Diagnostic Exam $100, per covered person, per 24 hour period
-Daily Hospital confinement $100/day for 365 days
-Hospital Intensive Care - $500 per day, per covered person, for up to 30 days

AGE RATES: HSSCR

18-49	**Employee**	**$7.92**	**E+Spouse**	**$14.52**	**E+Children**	**$10.98**	**Family**	**$14.76**
50-59	**Employee**	**$10.14**	**E+Spouse**	**$20.16**	**E+Children**	**$12.48**	**Family**	**$19.38**
60-75	**Employee**	**$13.20**	**E+Spouse**	**$25.26**	**E+Children**	**$16.38**	**Family**	**$27.00**

CONTACT: IRIS GOODALL, AFLAC ASSOCIATE: CELL: 502.608.5460;EMAIL: IGOODALL@BELLSOUTH.NET

SPENCER COUNTY-DISABILITY RATES

Rate sheet prepared by Web User on 5/10/2021 12:27:14 PM.
Kentucky Payroll Premium rates are Biweekly for industry Class B.

The rates shown on this insert page are for illustration purposes only; they do not imply coverage. For more information about policy/plan benefits and limitations, please refer to the accompanying product brochure for each insurance policy/plan listed below.

AFLAC-SHORT TERM DISABILITY - Series A-57600

Elimination Period Accident/Sickness - 0/14 DAYS

Annual Income		$18,000	$20,000	$22,000	$24,000	$26,000	$28,000	$30,000	$32,000	$34,000	$36,000
Benefit Period	**Age**	**$900**	**$1,000**	**$1,100**	**$1,200**	**$1,300**	**$1,400**	**$1,500**	**$1,600**	**$1,700**	**$1,800**
3 MONTHS	18-49	$9.18	$10.20	$11.22	$12.24	$13.26	$14.28	$15.30	$16.32	$17.34	$18.36
	50-64	$11.34	$12.60	$13.86	$15.12	$16.38	$17.64	$18.90	$20.16	$21.42	$22.68
	65-74	$13.50	$15.00	$16.50	$18.00	$19.50	$21.00	$22.50	$24.00	$25.50	$27.00

ON-THE-JOB ACCIDENT DISABILITY RIDER - Series A-57650

Annual Income		$9,000	$9,000	$12,000	$12,000	$16,000	$18,000	$20,000	$22,000	$24,000	$26,000
Benefit Period	**Age**	**$400**	**$500**	**$600**	**$700**	**$800**	**$900**	**$1,000**	**$1,100**	**$1,200**	**$1,300**
3 MONTHS	18-74	$2.40	$3.00	$3.60	$4.20	$4.80	$5.40	$6.00	$6.60	$7.20	$7.80

SPENCER COUNTY-DISABILITY RATES

Rate sheet prepared by Web User on 5/10/2021 12:32:41 PM.
Kentucky Payroll Premium rates are Biweekly for industry Class B.

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AFLAC-SHORT TERM DISABILITY - Series A-57600

Elimination Period Accident/Sickness - 0/14 DAYS

Annual Income		$38,000	$40,000	$42,000	$44,000	$46,000	$48,000	$50,000	$52,000	$54,000	$56,000
Benefit Period	**Age**	**$1,900**	**$2,000**	**$2,100**	**$2,200**	**$2,300**	**$2,400**	**$2,500**	**$2,600**	**$2,700**	**$2,800**
3 MONTHS	18-49	$19.38	$20.40	$21.42	$22.44	$23.46	$24.48	$25.50	$26.52	$27.54	$28.56
	50-64	$23.94	$25.20	$26.46	$27.72	$28.98	$30.24	$31.50	$32.76	$34.02	$35.28
	65-74	$28.50	$30.00	$31.50	$33.00	$34.50	$36.00	$37.50	$39.00	$40.50	$42.00

ON-THE-JOB ACCIDENT DISABILITY RIDER - Series A-57650

Annual Income		$18,000	$20,000	$22,000	$24,000	$26,000	$28,000	$30,000	$32,000	$34,000	$36,000
Benefit Period	**Age**	**$900**	**$1,000**	**$1,100**	**$1,200**	**$1,300**	**$1,400**	**$1,500**	**$1,600**	**$1,700**	**$1,800**
3 MONTHS	18-74	$5.40	$6.00	$6.60	$7.20	$7.80	$8.40	$9.00	$9.60	$10.20	$10.80

Ambulance & Helicopter Coverage

MASA Medical Transport Solutions™

FOR EMPLOYEES

Any Ground Ambulance. Any Air Ambulance. Nationwide.

Covers out-of-pocket costs for **ANY** Emergency Ground Ambulance or Emergency Medical Helicopter transport, *regardless* of provider!

What is covered?

Out-of-pocket costs for Emergency Air & Ground transports!

BENEFIT	EMERGENTPlus $14.00-Monthly	PLATINUM $39.00- Monthly
Emergency Air Medical Transport (Helicopter)	✓ (U.S. Only)	✓
Emergency Ground Ambulance Transport	✓ (U.S. Only)	✓
Repatriation -We'll fly you back home!	✓ (U.S. Only)	✓
Non-Emergent Air Transport	✓ (U.S. Only)	✓
Organ Retrieval		✓
Minor Child/Grandchild Return		✓
Organ Recipient Transport		✓
Non-injury Transport		✓
Pet Return		✓
Vehicle Return		✓
Return Transportation		✓
Escort Transportation		✓
Mortal Remains Transport		✓
Worldwide Coverage		✓

Pricing includes Family Coverage!

THE TRUTH....

Insurance doesn't fully cover ground & air transports…

Americans today **suffer from a false sense of security** that their medical coverage will pay for all costs associated with emergency or critical care transport. The reality is that a majority of Americans are **only partially covered** for these high costs.

Most policies now will only pay based off the "Maximum Allowable Amount."

Many providers in the state and throughout the country are OUT OF NETWORK with virtually all insurance carriers. Even if "In Network", providers still leave you owing *thousands* in **Co-Pays** and **Deductibles**.

You face the possibility that your medical coverage will deny the claim **leaving you responsible for the ENTIRE bill**.

With MASA, you will have **COMPREHENSIVE** financial protection for any emergent air or ground transport, REGARDLESS who transports you! **JOIN TODAY!**

Any Ground or Air Ambulance!

*Medical Repatriation (We'll fly you back)- If member is hospitalized while away from home, MASA will fly the member home, to a hospital of their choice. At no cost!

"All I had to do was send the bill which was never paid by TriCare for Life, and the rest is history. When MASA received that bill, it was paid and all amounts owed satisfied." --- MASA Member, 2015

MASA MTS for Employees Ensures…

- **Coverage in all 50 states**
- **Unlimited Usage**
- **NO claim forms or deductibles**
- **Covers Employee +Spouse/domestic partner & dependents up to age 26**

The Essential Employee Benefit

CHOOSE THE LIFELOCK SERVICE THAT'S RIGHT FOR YOU.

LIFELOCK™ BENEFIT ELITE identity theft protection is designed to help protect against identity theft plus monitor for threats to your identity and financial assets—your 401(k), investment, checking and savings accounts.† LifeLock Benefit Elite membership is only available as an employee payroll-deducted benefit.

LIFELOCK ULTIMATE PLUS™ service provides peace of mind knowing you have LifeLock's most comprehensive identity theft protection. Enhanced services include bank account application and takeover alerts, online annual three-bureau credit reports and credit scores plus monthly one-bureau credit score tracking.[1†]

The credit scores provided are VantageScore 3.0 credit scores based on data from Equifax, Experian and TransUnion respectively. Third parties use many different types of credit scores and are likely to use a different type of credit score to assess your creditworthiness.

LIFELOCK JUNIOR® (if dependents under age 18 are enrolled) protection helps safeguard your child's Social Security number and good name with proactive identity theft protection designed specifically for children.** To learn more about LifeLock Junior® service, please visit: LifeLock.com/products/lifelock-junior

Special employee benefit rate starting as low as

$3.92 BIWEEKLY

Based on biweekly deductions for LifeLock Benefit Elite service, employee only.

BIWEEKLY SERVICE PLAN OPTIONS	LifeLock Benefit Elite	LifeLock Ultimate Plus™
Employee Only [18 and over]	$3.92	$11.76
Employee + ** *Employee (primary) plus up to 6 (six) adult dependents (18-26) and 6 (six) Junior memberships.*	$7.84	$23.53

Children under the age of 18 will receive a product designed specifically for minors, LifeLock Junior membership. Enrollment in LifeLock membership is limited to employees and their eligible dependents. Please be advised that LifeLock services may only be provided after we receive certain information about you and each family member, as applicable. Please refer to employer group for the specific information that is required to complete the enrollment process. In the event you do not complete the enrollment process for your family members, as applicable, by submitting the required information for the selected plan (LifeLock Benefit Elite or LifeLock Ultimate Plus), those individuals will not receive LifeLock services under the plan, but you will continue to be charged the full amount of the monthly membership selected until you cancel or modify your membership plan at your employer's next open enrollment period, which may be annually. Please note that we will NOT refund or credit you for any period of time during which we are unable to provide LifeLock services to any family member on your plan after your benefit effective date due to your failure to submit the information necessary to complete the enrollment process. Please note that if you do not complete the enrollment process for each family member, you may be paying more for LifeLock services than you otherwise would if you had selected a lower tier plan.

SERVICE FEATURES	LifeLock Benefit Elite	LifeLock Ultimate Plus™
LifeLock Identity Alert™ System†	✓	✓
Dark Web Monitoring	✓	✓
LifeLock Privacy Monitor™	✓	✓
Address Change Verification	✓	✓
Lost Wallet Protection	✓	✓
Reduced Pre-Approved Credit Card Offers	✓	✓
Fictitious Identity Monitoring	✓	✓
Court Records Scanning	✓	✓
Data Breach Notifications	✓	✓
Credit, Checking & Savings Account Activity Alerts†	✓	✓
Checking and Savings Account Application Alerts†		✓
Bank Account Takeover Alerts†		✓
Investment Account Activity Alerts†	✓	✓
Three-Bureau Credit Monitoring[1,2]		✓
Three-Bureau Annual Credit Reports & Credit Scores[1] The credit scores provided are VantageScore 3.0 credit scores based on data from Equifax, Experian and TransUnion respectively. Third parties use many different types of credit scores and are likely to use a different type of credit score to assess your creditworthiness.		✓
One-Bureau Monthly Credit Score Tracking[1] The credit score provided is a VantageScore 3.0 credit score based on Equifax data. Third parties use many different types of credit scores and are likely to use a different type of credit score to assess your creditworthiness.		✓
File-Sharing Network Searches		✓
Sex Offender Registry Reports		✓
Priority Live Member Support		✓
U.S.-Based Identity Restoration Specialists	✓	✓
Stolen Funds Reimbursement*	Up to $1 Million	Up to $1 Million
Personal Expense Compensation*	Up to $1 Million	Up to $1 Million
Coverage for Lawyers and Experts*	Up to $1 Million	Up to $1 Million

** Indicates features included within the Million Dollar Protection™ Package†††*

LifeLock uses proprietary technology to detect† a variety of identity threats. If you have an ID problem, our U.S.-Based team of specialists can help fix it. It pays to have the comprehensive protection of LifeLock.

[1] Credit reports, scores and credit monitoring may require an additional verification process and credit services will be withheld until such process is complete. A reduced service fee may be charged until you verify your identity. If you were enrolled via your Employee Benefit program or a LifeLock Partner, you will continue to be charged the negotiated price.

[2] For LifeLock Ultimate Plus™ Three-Bureau credit monitoring, credit monitoring from Experian and TransUnion will take several days to begin.

No one can prevent all identity theft.

† LifeLock does not monitor all transactions at all businesses.

** LifeLock Junior™ membership is available only as an added membership to an adult LifeLock plan. Children under the age of 18 will receive a product designed specifically for minors, LifeLock Junior service. Enrollment in LifeLock service is limited to employees and their eligible dependents.

††† Reimbursement and Expense Compensation, each with limits of up to $1 million for Benefit Elite and Ultimate Plus. And up to $1 million for coverage for lawyers and experts if needed, for all plans. Benefits provided by Master Policy issued by United Specialty Insurance Company, Inc. (State National Insurance Company, Inc. for NY State members). Policy terms, conditions and exclusions at: LifeLock.com/legal.

BENEFIT SUMMARIES AND NOTICES

IMPORTANT NOTICES REGARDING EMPLOYEE BENEFITS

COBRA Information: COBRA continuation coverage is a temporary extension of coverage under the group health plan. the right to COBRA continuation coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

HIPAA Special Enrollment Rights Notice: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Women's Health and Cancer Rights Act of 1998 (WHCRA): WHCRA requires a group health plan to notify you, as a participant or a beneficiary, of your potential rights related to coverage in connection with a mastectomy. Your plan may provide medical and surgical benefits in connection with a mastectomy and reconstructive surgery. If it does, coverage will be provide in a manner determined in consultation with your attending physician and the patient for a) all stages of reconstruction on the breast on which the mastectomy was performed; b)surgery and reconstruction of the other breast to produce a symmetrical appearance; c) prostheses; and d) treatment of physical complications of the mastectomy, including lymphedema. The coverage, if available under your group health plan, is subject to the same deductible and coinsurance applicable to other medical and surgical benefits provided under the plan. For specific information, please refer to your summary plan description or benefits booklet, or contact Humana Resources.

Notice Regarding Wellness Program: For those employers offering a wellness program, including those that are included with the group health plan, please note it is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You may be asked to complete a biometric screening, which will include a blood test. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program may receive an incentive for specific activities completed. Although you are not required to complete the HRA or participate in the biometric screening, employees who do so may receive an incentive. Additional incentives may be available for employees who participate in certain health-related activities or achieve certain health outcomes. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting your Human Resources Department.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program may use aggregate information it collects to design a program based on identified health risks in the workplace, your personal information will never be disclosed either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are possibly a doctor, nurse or health coach in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact your Human Resources Department.

Cafeteria Plan Pretax Salary Reduction Agreement: In accordance with your rights under the Plan, if you elect to receive benefit coverage under the Plan, you understand that an amount equal to the annual contributions for the coverage you elect, divided by the number of pay periods in the Plan Year, will be deducted on a pretax basis from each paycheck to pay for elected coverage. You cannot change or revoke this agreement as of any date prior to the next Plan Year, unless a Change in Election Event occurs as defined in the Plan (e.g., termination of employment, divorce, marriage), and the election change is on account of and consistent with the Change in Election Event, as described in the Plan. However, any HSA contribution election can be changed at any time, for any reason, effective no later than the first day of the calendar month after the change request is filed. Your compensation will be reduced by the amount of your required contribution for the benefits that you have elected under the Plan and such salary reductions will continue for each pay period until amended or terminated.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

Kentucky Medicaid:
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov

KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718

Indiana Medicaid:
Healthy Indiana Plan for low-income adults 19-64: Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479

All other Medicaid
Website: https://www.in.gov/medicaid/
Phone 1-800-457-4584

To see if any other states have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

Your summary of benefits

Anthem

Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Blue Access PPO Option A28 with Rx Option T1

Your Network: Blue Access

ALTERNATE PLAN

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$5,000 person / $10,000 family	$15,000 person / $30,000 family
Out-of-Pocket Limit	$7,000 person / $14,000 family	$21,000 person / $42,000 family
The family deductible and out-of-pocket maximum are embedded, meaning the cost shares of one family member will be applied to both per person deductible and per person out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the per person deductible or per person out-of-pocket maximum. All medical and prescription drug deductibles, copayments and coinsurance apply toward the out-of-pocket maximum (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services). In-network and out-of-network deductibles and out-of-pocket maximum amounts are separate and do not accumulate toward each other.		
Preventive Care / Screening / Immunization	No charge	30% coinsurance after medical deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	30% coinsurance after medical deductible is met
<u>Virtual Care (Telemedicine / Telehealth Visits)</u> Virtual Visits - Online visits with Doctors who also provide services in person Primary Care (PCP)	<u>Preferred PCP</u> $20 copay per visit medical deductible does not apply <u>PCP</u> $30 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Mental Health and Substance Abuse care	$30 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Specialist	$75 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Medical Chats and Virtual (Video) Visits for Primary Care from our Online Provider K Health, through its affiliated Provider groups	No charge	
Virtual Visits from Online Provider LiveHealth Online *via www.livehealthonline.com; our mobile app, website or Anthem-enabled device*		
Primary Care (PCP) and Mental Health and Substance Abuse	$20 copay per visit medical deductible does not apply	
Specialist Care	$75 copay per visit medical deductible does not apply	
Visits in an Office		
Primary Care (PCP)	Preferred PCP $20 copay per visit medical deductible does not apply PCP $30 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Specialist Care	$75 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	0% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Retail Health Clinic	$30 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Manipulation Therapy *Coverage is limited to 12 visits per benefit period.*	$30 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
<u>Other Services in an Office</u>		
Allergy Testing *When Allergy injections are billed separately by network providers, the member is responsible for a $10 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.*	0% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Chemo/Radiation Therapy	$75 copay per visit medical deductible does not apply‡	30% coinsurance after medical deductible is met
Dialysis/Hemodialysis	$75 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Prescription Drugs *Dispensed in the office*	0% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Surgery	$75 copay per visit medical deductible does not apply‡	30% coinsurance after medical deductible is met
<u>Diagnostic Services</u> Lab		
Office	No charge	30% coinsurance after medical deductible is met
Freestanding Lab/Reference Lab	No charge	30% coinsurance after medical deductible is met
Outpatient Hospital	0% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
X-Ray		
Office	No charge	30% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	0% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	0% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Freestanding Radiology Center	0% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Outpatient Hospital	0% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
<u>Emergency and Urgent Care</u>		
Urgent Care	$30 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	$300 copay per visit and 0% coinsurance medical deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services	0% coinsurance medical deductible does not apply	Covered as In-Network
Ambulance	0% coinsurance after medical deductible is met	Covered as In-Network
<u>Outpatient Mental Health and Substance Abuse</u>		
Doctor Office Visit	$30 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Facility Visit		
Facility Fees	0% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Doctor Services	0% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
<u>Outpatient Surgery</u> Facility Fees		
Hospital	0% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Freestanding Surgical Center	0% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Doctor and Other Services		
Hospital	0% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Freestanding Surgical Center	0% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
<u>Hospital (Including Maternity, Mental Health and Substance Abuse)</u>		
Facility Fees	0% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Human Organ and Tissue Transplants *Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.*	No charge	50% coinsurance after medical deductible is met
Doctor and other services	0% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
<u>Recovery & Rehabilitation</u>		
Home Health Care *Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.*	0% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Rehabilitation services *You are responsible for cost shares no greater than the PCP office visit when Covered Services are performed by a Physical Therapist or Occupational Therapist.* *Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 20 visits per benefit period.* *Coverage for rehabilitative and habilitative speech therapy is limited to 20 visits per benefit period.*		
Office	$30 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Outpatient Hospital	0% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Cardiac rehabilitation *Coverage is limited to 36 visits per benefit period.*		
Office	$75 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Outpatient Hospital	0% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Pulmonary rehabilitation *Coverage is limited to 20 visits per benefit period.*		
Office	$75 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Outpatient Hospital	0% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Skilled Nursing Care (facility) *Coverage for Skilled Nursing, Outpatient Rehabilitation and Inpatient Rehabilitation facility settings is limited to 150 days combined per benefit period.*	0% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Inpatient Hospice	No charge	No charge
Durable Medical Equipment	50% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	50% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	Not applicable	Not applicable	Not applicable
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with In-Network medical out-of-pocket limit	Combined with Non-Network medical out-of-pocket limit
Prescription Drug Coverage *Cost shares for drugs included on the Essential drug list appear below. Drugs not included on the Essential drug list will not be covered. Your plan uses the Rx Choice Tiered Network. You may receive up to a 90 day supply of medication at Retail 90 pharmacies.*			
Home Delivery Pharmacy *Maintenance medication are available through IngenioRx Home Delivery Pharmacy. You may get two 30-day supply fills of the same maintenance medication at a retail pharmacy. Prior to your 3rd fill, you must call us on the number on your ID card and tell us if you would like to keep getting your maintenance medications from a retail pharmacy or if you would like to use home delivery. If you do not contact us, you will pay the full retail cost of any maintenance medication until you inform us of your decision.*			
Tier 1 - Typically Generic *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$10 copay per prescription, deductible does not apply (retail) and $25 copay per prescription, deductible does not apply (home delivery)	$20 copay per prescription, deductible does not apply (retail) and Not covered (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$35 copay per prescription, deductible does not apply (retail) and $105 copay per prescription, deductible does not apply (home delivery)	$45 copay per prescription, deductible does not apply (retail) and Not covered (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$75 copay per prescription, deductible does not apply (retail) and $225 copay per prescription, deductible	$85 copay per prescription, deductible does not apply (retail) and Not covered (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
	does not apply (home delivery)		
Tier 4 - Typically Specialty (brand and generic) *Per 30 day supply (specialty pharmacy).*	25% coinsurance up to $350 per prescription, deductible does not apply (retail and home delivery)	25% coinsurance up to $450 per prescription, deductible does not apply (retail) and Not covered (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your vision coverage. Only children's vision services count towards your out of pocket limit.		
Children's Vision (up to age 21) Child Vision Deductible	$0 person	$0 person
Vision exam *Limited to 1 exam per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Adult Vision (age 21 and older) Adult Vision Deductible	$0 person	$0 person
Vision exam *Limited to 1 exam per benefit period.*	No charge	Reimbursed Up to $42

Notes:

- Dependent age: to end of the month in which the child attains age 26.
- Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help the member know if the services are considered not medically necessary.
- No charge means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- If you have an office visit with your Primary Care Physician, Specialist or Urgent Care at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under “Outpatient Facility Services”.
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.

Your summary of benefits

Anthem

CORE PLAN

Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Blue Access PPO Option A22 with Rx Option T1

Your Network: Blue Access

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$2,500 person / $5,000 family	$7,500 person / $15,000 family
Out-of-Pocket Limit	$6,500 person / $13,000 family	$19,500 person / $39,000 family
The family deductible and out-of-pocket maximum are embedded, meaning the cost shares of one family member will be applied to both per person deductible and per person out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the per person deductible or per person out-of-pocket maximum. All medical and prescription drug deductibles, copayments and coinsurance apply toward the out-of-pocket maximum (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services). In-network and out-of-network deductibles and out-of-pocket maximum amounts are separate and do not accumulate toward each other.		
Preventive Care / Screening / Immunization	No charge	50% coinsurance after medical deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	50% coinsurance after medical deductible is met
Virtual Care (Telemedicine / Telehealth Visits) Virtual Visits - Online visits with Doctors who also provide services in person Primary Care (PCP)	Preferred PCP $10 copay per visit medical deductible does not apply PCP $20 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Mental Health and Substance Abuse care	$20 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Specialist	$50 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Medical Chats and Virtual (Video) Visits for Primary Care from our Online Provider K Health, through its affiliated Provider groups	No charge	
Virtual Visits from Online Provider LiveHealth Online *via www.livehealthonline.com; our mobile app, website or Anthem-enabled device*		
Primary Care (PCP) and Mental Health and Substance Abuse	$10 copay per visit medical deductible does not apply	
Specialist Care	$50 copay per visit medical deductible does not apply	
Visits in an Office		
Primary Care (PCP)	Preferred PCP $10 copay per visit medical deductible does not apply PCP $20 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Specialist Care	$50 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Retail Health Clinic	$20 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Manipulation Therapy *Coverage is limited to 12 visits per benefit period.*	$20 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
<u>Other Services in an Office</u>		
Allergy Testing *When Allergy injections are billed separately by network providers, the member is responsible for a $10 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.*	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Chemo/Radiation Therapy	$50 copay per visit medical deductible does not apply‡	50% coinsurance after medical deductible is met
Dialysis/Hemodialysis	$50 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Prescription Drugs *Dispensed in the office*	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Surgery	$50 copay per visit medical deductible does not apply‡	50% coinsurance after medical deductible is met
<u>Diagnostic Services</u> Lab		
Office	No charge	50% coinsurance after medical deductible is met
Freestanding Lab/Reference Lab	No charge	50% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
X-Ray		
Office	No charge	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Freestanding Radiology Center	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
<u>Emergency and Urgent Care</u>		
Urgent Care	$20 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	$300 copay per visit and 20% coinsurance medical deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance medical deductible does not apply	Covered as In-Network
Ambulance	20% coinsurance after medical deductible is met	Covered as In-Network
<u>Outpatient Mental Health and Substance Abuse</u>		
Doctor Office Visit	$20 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Facility Visit		
Facility Fees	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Doctor Services	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
<u>Outpatient Surgery</u> Facility Fees		
Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Freestanding Surgical Center	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Doctor and Other Services		
Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Freestanding Surgical Center	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
<u>Hospital (Including Maternity, Mental Health and Substance Abuse)</u> Facility Fees	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Human Organ and Tissue Transplants *Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.*	No charge	50% coinsurance after medical deductible is met
Doctor and other services	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
<u>Recovery & Rehabilitation</u> Home Health Care *Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.*	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Rehabilitation services *You are responsible for cost shares no greater than the PCP office visit when Covered Services are performed by a Physical Therapist or Occupational Therapist.* *Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 20 visits per benefit period.* *Coverage for rehabilitative and habilitative speech therapy is limited to 20 visits per benefit period.*		
Office	$20 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Cardiac rehabilitation *Coverage is limited to 36 visits per benefit period.*		
Office	$50 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Pulmonary rehabilitation *Coverage is limited to 20 visits per benefit period.*		
Office	$50 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Skilled Nursing Care (facility) *Coverage for Skilled Nursing, Outpatient Rehabilitation and Inpatient Rehabilitation facility settings is limited to 150 days combined per benefit period.*	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Inpatient Hospice	No charge	No charge
Durable Medical Equipment	50% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	50% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	Not applicable	Not applicable	Not applicable
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with In-Network medical out-of-pocket limit	Combined with Non-Network medical out-of-pocket limit
Prescription Drug Coverage *Cost shares for drugs included on the Essential drug list appear below. Drugs not included on the Essential drug list will not be covered. Your plan uses the Rx Choice Tiered Network. You may receive up to a 90 day supply of medication at Retail 90 pharmacies.*			
Home Delivery Pharmacy *Maintenance medication are available through IngenioRx Home Delivery Pharmacy. You may get two 30-day supply fills of the same maintenance medication at a retail pharmacy. Prior to your 3rd fill, you must call us on the number on your ID card and tell us if you would like to keep getting your maintenance medications from a retail pharmacy or if you would like to use home delivery. If you do not contact us, you will pay the full retail cost of any maintenance medication until you inform us of your decision.*			
Tier 1 - Typically Generic *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$10 copay per prescription, deductible does not apply (retail) and $25 copay per prescription, deductible does not apply (home delivery)	$20 copay per prescription, deductible does not apply (retail) and Not covered (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$35 copay per prescription, deductible does not apply (retail) and $105 copay per prescription, deductible does not apply (home delivery)	$45 copay per prescription, deductible does not apply (retail) and Not covered (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$75 copay per prescription, deductible does not apply (retail) and $225 copay per prescription, deductible	$85 copay per prescription, deductible does not apply (retail) and Not covered (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
	does not apply (home delivery)		
Tier 4 - Typically Specialty (brand and generic) *Per 30 day supply (specialty pharmacy).*	25% coinsurance up to $350 per prescription, deductible does not apply (retail and home delivery)	25% coinsurance up to $450 per prescription, deductible does not apply (retail) and Not covered (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your vision coverage. Only children's vision services count towards your out of pocket limit.		
Children's Vision (up to age 21) Child Vision Deductible	$0 person	$0 person
Vision exam *Limited to 1 exam per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Adult Vision (age 21 and older) Adult Vision Deductible	$0 person	$0 person
Vision exam *Limited to 1 exam per benefit period.*	No charge	Reimbursed Up to $42

Notes:

- Dependent age: to end of the month in which the child attains age 26.
- Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help the member know if the services are considered not medically necessary.
- No charge means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- If you have an office visit with your Primary Care Physician, Specialist or Urgent Care at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under “Outpatient Facility Services”.
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.

Your summary of benefits

Anthem

Anthem® Blue Cross and Blue Shield

BUY UP PLAN

Your Plan: Anthem Blue Access PPO Option A4 with Rx Option T1

Your Network: Blue Access

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$500 person / $1,500 family	$1,500 person / $3,000 family
Out-of-Pocket Limit	$4,000 person / $8,000 family	$12,000 person / $24,000 family
The family deductible and out-of-pocket maximum are embedded, meaning the cost shares of one family member will be applied to both per person deductible and per person out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the per person deductible or per person out-of-pocket maximum. All medical and prescription drug deductibles, copayments and coinsurance apply toward the out-of-pocket maximum (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services). In-network and out-of-network deductibles and out-of-pocket maximum amounts are separate and do not accumulate toward each other.		
Preventive Care / Screening / Immunization	No charge	50% coinsurance after medical deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	50% coinsurance after medical deductible is met
Virtual Care (Telemedicine / Telehealth Visits) Virtual Visits - Online visits with Doctors who also provide services in person Primary Care (PCP)	Preferred PCP $10 copay per visit medical deductible does not apply PCP $20 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Mental Health and Substance Abuse care	$20 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Specialist	$50 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Medical Chats and Virtual (Video) Visits for Primary Care from our Online Provider K Health, through its affiliated Provider groups	No charge	
Virtual Visits from Online Provider LiveHealth Online *via www.livehealthonline.com; our mobile app, website or Anthem-enabled device*		
Primary Care (PCP) and Mental Health and Substance Abuse	$10 copay per visit medical deductible does not apply	
Specialist Care	$50 copay per visit medical deductible does not apply	
Visits in an Office		
Primary Care (PCP)	Preferred PCP $10 copay per visit medical deductible does not apply PCP $20 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Specialist Care	$50 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Retail Health Clinic	$20 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Manipulation Therapy *Coverage is limited to 12 visits per benefit period.*	$20 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
<u>Other Services in an Office</u>		
Allergy Testing *When Allergy injections are billed separately by network providers, the member is responsible for a $10 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.*	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Chemo/Radiation Therapy	$50 copay per visit medical deductible does not apply‡	50% coinsurance after medical deductible is met
Dialysis/Hemodialysis	$50 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Prescription Drugs *Dispensed in the office*	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Surgery	$50 copay per visit medical deductible does not apply‡	50% coinsurance after medical deductible is met
<u>Diagnostic Services</u> Lab		
Office	No charge	50% coinsurance after medical deductible is met
Freestanding Lab/Reference Lab	No charge	50% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
X-Ray		
Office	No charge	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Freestanding Radiology Center	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
<u>Emergency and Urgent Care</u>		
Urgent Care	$20 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	$300 copay per visit and 20% coinsurance medical deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance medical deductible does not apply	Covered as In-Network
Ambulance	20% coinsurance after medical deductible is met	Covered as In-Network
<u>Outpatient Mental Health and Substance Abuse</u>		
Doctor Office Visit	$20 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Facility Visit		
Facility Fees	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Doctor Services	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
<u>Outpatient Surgery</u> Facility Fees		
Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Freestanding Surgical Center	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Doctor and Other Services		
Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Freestanding Surgical Center	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
<u>Hospital (Including Maternity, Mental Health and Substance Abuse)</u> Facility Fees	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Human Organ and Tissue Transplants *Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.*	No charge	50% coinsurance after medical deductible is met
Doctor and other services	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
<u>Recovery & Rehabilitation</u> Home Health Care *Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.*	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Rehabilitation services *You are responsible for cost shares no greater than the PCP office visit when Covered Services are performed by a Physical Therapist or Occupational Therapist.* *Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 20 visits per benefit period.* *Coverage for rehabilitative and habilitative speech therapy is limited to 20 visits per benefit period.*		
Office	$20 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Cardiac rehabilitation *Coverage is limited to 36 visits per benefit period.*		
Office	$50 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Pulmonary rehabilitation *Coverage is limited to 20 visits per benefit period.*		
Office	$50 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Skilled Nursing Care (facility) *Coverage for Skilled Nursing, Outpatient Rehabilitation and Inpatient Rehabilitation facility settings is limited to 150 days combined per benefit period.*	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Inpatient Hospice	No charge	No charge
Durable Medical Equipment	50% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	50% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	Not applicable	Not applicable	Not applicable
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with In-Network medical out-of-pocket limit	Combined with Non-Network medical out-of-pocket limit
Prescription Drug Coverage *Cost shares for drugs included on the Essential drug list appear below. Drugs not included on the Essential drug list will not be covered. Your plan uses the Rx Choice Tiered Network. You may receive up to a 90 day supply of medication at Retail 90 pharmacies.*			
Home Delivery Pharmacy *Maintenance medication are available through IngenioRx Home Delivery Pharmacy. You may get two 30-day supply fills of the same maintenance medication at a retail pharmacy. Prior to your 3rd fill, you must call us on the number on your ID card and tell us if you would like to keep getting your maintenance medications from a retail pharmacy or if you would like to use home delivery. If you do not contact us, you will pay the full retail cost of any maintenance medication until you inform us of your decision.*			
Tier 1 - Typically Generic *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$10 copay per prescription, deductible does not apply (retail) and $25 copay per prescription, deductible does not apply (home delivery)	$20 copay per prescription, deductible does not apply (retail) and Not covered (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$35 copay per prescription, deductible does not apply (retail) and $105 copay per prescription, deductible does not apply (home delivery)	$45 copay per prescription, deductible does not apply (retail) and Not covered (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$75 copay per prescription, deductible does not apply (retail) and $225 copay per prescription, deductible	$85 copay per prescription, deductible does not apply (retail) and Not covered (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
	does not apply (home delivery)		
Tier 4 - Typically Specialty (brand and generic) *Per 30 day supply (specialty pharmacy).*	25% coinsurance up to $350 per prescription, deductible does not apply (retail and home delivery)	25% coinsurance up to $450 per prescription, deductible does not apply (retail) and Not covered (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your vision coverage. Only children's vision services count towards your out of pocket limit.		
Children's Vision (up to age 21) Child Vision Deductible	$0 person	$0 person
Vision exam *Limited to 1 exam per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Adult Vision (age 21 and older) Adult Vision Deductible	$0 person	$0 person
Vision exam *Limited to 1 exam per benefit period.*	No charge	Reimbursed Up to $42

Notes:

- Dependent age: to end of the month in which the child attains age 26.
- Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help the member know if the services are considered not medically necessary.
- No charge means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- If you have an office visit with your Primary Care Physician, Specialist or Urgent Care at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under “Outpatient Facility Services”.
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.

- ‡ Your cost share will be reduced when services are provided in a PCP's office.

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

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(TTY/TDD: 711)

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