

Employee Enrollment Application



Your Anthem enrollment application is inside. It is essential that you read it carefully and complete all necessary sections.

If you are a new enrollee

- Applying for health, vision and/or dental benefits, please complete Sections 1, 3, 4, 5, 6, 7, 8 and 9. Your signature is required in Section 9.
- Waiving any or all benefits, please complete Sections 1, 4, and 10. Your signature is required in Section 10.

If you are adding a dependent(s)

Complete Section 2 in addition to the above.

It is important that you read and understand the Significant Terms, Conditions and Authorizations in Section 9.

Thank you for choosing
Anthem Blue Cross and Blue Shield.
www.anthem.com

Note: You may be required to supply additional information.

Anthem provides administrative claims payment services only, and does not assume any financial risk or obligation with respect to claims.

Anthem Blue Cross and Blue Shield is the trade name of: In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Ohio: Community Insurance Company. In Wisconsin: Blue Cross Blue Shield of Wisconsin ("BCBSWI"), which underwrites or administers the PPO and indemnity policies; Compcare Health Services Insurance Corporation ("Compcare"), which underwrites or administers the HMO policies; and Compcare and BCBSWI collectively, which underwrite or administer the POS policies. Independent licensees of the Blue Cross and Blue Shield Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are the registered marks of the Blue Cross and Blue Shield Association.

Enrollment Application



Anthem provides administrative claims payment services only, and does not assume any financial risk or obligation with respect to claims.

Please complete this form in ink and return to your employer. Use extra sheets of paper if necessary.

All information given should apply to this employer. Anthem's Primary Care Physician (PCP) listings, for HMO/POS products can be obtained through www.anthem.com.

EMPLOYER USE ONLY			
Group no.	Sub-group no.	Applicant no./dept. name	Request effective date (MM/DD/YYYY)
Employer name		Address (please include suite no., city, state, ZIP code)	
ANTHEM USE ONLY			
Plan	PCP <input type="checkbox"/> Yes <input type="checkbox"/> No	COB <input type="checkbox"/> Yes <input type="checkbox"/> No	
Health effective date (MM/DD/YYYY)	Dental effective date (MM/DD/YYYY)	Vision effective date (MM/DD/YYYY)	Pre-ex date (MM/DD/YYYY)

Section 1. REASON FOR APPLICATION			
<input type="checkbox"/> New enrollment	<input type="checkbox"/> Waiver	<input type="checkbox"/> Add dependent (see Section 2)	<input type="checkbox"/> Rehire (event date) _____
<input type="checkbox"/> New hire	<input type="checkbox"/> Annual open enrollment	<input type="checkbox"/> COBRA Qualifying event _____	<input type="checkbox"/> Conversion (event date) _____
Section 2. STATUS CHANGE/EVENT			
<input type="checkbox"/> Event date (MM/DD/YYYY)	<input type="checkbox"/> Marriage <input type="checkbox"/> Birth	<input type="checkbox"/> Adoption* <input type="checkbox"/> Legal guardianship* <i>*Include legal documentation.</i>	<input type="checkbox"/> Other _____
Section 3. TYPE OF COVERAGE/PLAN			
Health coverage	Dental coverage	Vision coverage	
<input type="checkbox"/> HMO* ¹ (except Ohio) <input type="checkbox"/> EPO (Ohio only) <input type="checkbox"/> PPO _____ <input type="checkbox"/> POS <input type="checkbox"/> Blue Traditional® <input type="checkbox"/> Anthem Essential SM Choice PPO <input type="checkbox"/> Blue Access SM Hospital Surgical PPO (IN, KY, OH only) <input type="checkbox"/> Blue Access SM Choice Hospital Surgical PPO (MO only) <input type="checkbox"/> Blue Preferred® ASO/EPO <input type="checkbox"/> Lumenos® Health Savings Account <input type="checkbox"/> Lumenos® Health Reimbursement Account <input type="checkbox"/> Lumenos® Health Incentive Account <input type="checkbox"/> Lumenos® Health Incentive Account Plus <input type="checkbox"/> Anthem Essential SM PPO <input type="checkbox"/> Anthem Essential SM Select (MO only) <input type="checkbox"/> Blue Access SM Hospital Surgical PPO (MO only) <input type="checkbox"/> Blue Preferred® Select (MO only) <input type="checkbox"/> Blue Preferred® Plus Hospital Surgical POS (WI only)	<input type="checkbox"/> PPO <input type="checkbox"/> Traditional (IN, OH only) <input type="checkbox"/> Dental Blue® 100/200/300 <input type="checkbox"/> Dental Blue® 100	<input type="checkbox"/> Vision	
<input type="checkbox"/> Employee only <input type="checkbox"/> Employee and spouse <input type="checkbox"/> Employee and child(ren) <input type="checkbox"/> Family coverage <input type="checkbox"/> No coverage	<input type="checkbox"/> Employee only <input type="checkbox"/> Employee and spouse <input type="checkbox"/> Employee and child(ren) <input type="checkbox"/> Family coverage <input type="checkbox"/> No coverage	<input type="checkbox"/> Employee only <input type="checkbox"/> Employee and spouse <input type="checkbox"/> Employee and child(ren) <input type="checkbox"/> Family coverage <input type="checkbox"/> No coverage	
¹ Ohio only-a health insuring corporation product or "HIC" Anthem will facilitate the opening of a Health Savings Account in your name, if directed by your Employer.			
Section 4. EMPLOYEE INFORMATION (*Only complete Primary Care Physician (PCP) information when enrolling in HMO or POS products.)			
Social security no. (required)	Last name	First name	M.I. Age Date of birth (MM/DD/YYYY)
Home address (street, city, state, ZIP code)		County (KY residents include municipality)	<input type="checkbox"/> Single <input type="checkbox"/> Divorced Sex <input type="checkbox"/> Married <input type="checkbox"/> M <input type="checkbox"/> F
Home phone	Work phone	E-mail address	Are you retired? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No
Occupation	Full-time hire date (MM/DD/YYYY)	Income reported by <input type="checkbox"/> W2 <input type="checkbox"/> 1099 <input type="checkbox"/> Other _____	Hours working per week
Anthem PCP name*	Anthem PCP address*	Anthem PCP ID no.*	New patient?* <input type="checkbox"/> Yes <input type="checkbox"/> No

Policyholder name	Policyholder social security no.
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Section 5. FAMILY INFORMATION – Spouse and dependents to be enrolled. Attach a separate sheet if necessary.

Please read the Genetic Information Non-discrimination Act (GINA) information under Significant Terms, Conditions and Authorizations section, prior to answering questions below.

1 – Relationship to employee: Spouse Domestic Partner (DP)

Dependent name (last name, first name, M.I.)	Social security no. (required for spouse or DP)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth
Is dependent's address different than applicant's address? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide full address _____		Court ordered health care benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, include legal documentation)	Currently hospitalized or disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, give reason)
Anthem PCP name*	Anthem PCP address*	Anthem PCP ID no.*	New patient?*
			<input type="checkbox"/> Yes <input type="checkbox"/> No

2 – Relationship to employee: Son Daughter Other _____

Dependent name (last name, first name, M.I.)	Social security no.	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth
Is dependent's address different than applicant's address? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide full address _____		Court ordered health care benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, include legal documentation)	Currently hospitalized or disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, give reason)
Anthem PCP name*	Anthem PCP address*	Anthem PCP ID no.*	New patient?*
			<input type="checkbox"/> Yes <input type="checkbox"/> No

3 – Relationship to employee: Son Daughter Other _____

Dependent name (last name, first name, M.I.)	Social security no.	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth
Is dependent's address different than applicant's address? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide full address _____		Court ordered health care benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, include legal documentation)	Currently hospitalized or disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, give reason)
Anthem PCP name*	Anthem PCP address*	Anthem PCP ID no.*	New patient?*
			<input type="checkbox"/> Yes <input type="checkbox"/> No

Section 6. OTHER HEALTH COVERAGE Please check one: Yes (complete below) No

On the day your coverage begins, list family members, including yourself, who will be covered by any other health coverage.

Name of person(s) covered	Relationship to employee <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)	Name of the HMO or insurance company	Policy/certificate no.
Address of the HMO or insurance company		Phone no. of HMO or insurance company	Effective date (MM/DD/YYYY)
Policyholder name		Policyholder social security no.	Policyholder date of birth

Section 7. MEDICARE COVERAGE If you or your dependents are enrolled in Medicare or Medicaid, complete the following.

1 – Name of enrollee (last name, first name, M.I.)

Medicare Part A effective date	Medicare Part B effective date
Medicare/Medicaid ID no.	ESRD onset date
Medicare Part D ID no.	Medicare Part D carrier
Reason for Medicare entitlement <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> End stage renal disease (ESRD) <input type="checkbox"/> ESRD and disability	Medicare Part D effective date
Medicare Part D term date	

2 – Name of enrollee (last name, first name, M.I.)

Medicare Part A effective date	Medicare Part B effective date
Medicare/Medicaid ID no.	ESRD onset date
Medicare Part D ID no.	Medicare Part D carrier
Reason for Medicare entitlement <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> End stage renal disease (ESRD) <input type="checkbox"/> ESRD and disability	Medicare Part D effective date
Medicare Part D term date	

*Only complete Primary Care Physician (PCP) information for HMO or POS products.

Policyholder name	Policyholder social security no.
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Section 8. PRIOR HEALTH COVERAGE. Please check one: Yes (complete below) No

Have you been covered by Anthem within the past two (2) years? <input type="checkbox"/> Yes <input type="checkbox"/> No	Group name/ID no.	Dates policy in effect
Policy/Certificate no.		
Have you and/or your dependents had prior coverage with another carrier(s) in the past two (2) years? <input type="checkbox"/> Yes <input type="checkbox"/> No	List prior carrier(s)	Dates policy in effect
Please check the type of prior coverage: <input type="checkbox"/> Employee only <input type="checkbox"/> Employee and spouse <input type="checkbox"/> Employee and child(ren) <input type="checkbox"/> Employee/spouse/child(ren)		
Termination reason: <input type="checkbox"/> Divorce/legal separation <input type="checkbox"/> Death of spouse <input type="checkbox"/> COBRA coverage exhausted <input type="checkbox"/> Group plan terminated <input type="checkbox"/> Employer/group contribution ceased <input type="checkbox"/> Employment terminated <input type="checkbox"/> Other _____		

Section 9. SIGNIFICANT TERMS, CONDITIONS AND AUTHORIZATION (TERMS)

Genetic Information Non-discrimination Act (GINA): When answering questions on this enrollment application, the information provided for each individual should include only information about that individual, and should not include any genetic information. Genetic information includes family medical history and information related to the individual's genetic testing, genetic services, genetic counseling, or genetic diseases for which the individual may be at risk. All responses pertaining to an individual will only be considered and applied to the individual in question.

Health Savings Account Notice: Except as otherwise provided in any agreement between me and *the financial custodian*, the custodian of my Health Savings Account (HSA), I understand that my authorization is required before *the financial custodian* may provide Anthem Blue Cross and Blue Shield with information regarding my HSA. I hereby authorize *the financial custodian* to provide Anthem Blue Cross and Blue Shield with information about my HSA, including account number, account balance and information, regarding account activity. I also understand that I may provide Anthem Blue Cross and Blue Shield with a written request to revoke my authorization at any time.

Please read this section carefully before signing the application.

- I may not assign any payment under my Anthem Blue Cross and Blue Shield administered benefit plan.
- I authorize deduction from my wages/pension, if necessary for the required payment for the benefit for which I, or any dependents have applied.
- I am applying for the benefit selected on this application. If I select a coverage, or combination of coverages, not available to me and/or a class for which I am not eligible, I agree that my selection(s) is hereby automatically amended to be consistent with the employer's application.
- I understand that, to the extent permitted by law, Anthem reserves the right to accept or decline this application and that no right whatsoever is created by this application. I also understand that this coverage, if approved, may exclude for pre-existing conditions.
- I am responsible to timely notify my employer of any change that would make me or any dependent ineligible for benefits.
- By signing this application, I agree and consent to the recording and/or monitoring of any telephone conversation between Anthem and myself.

I acknowledge that I have read the Significant Terms, Conditions and Authorizations, and I accept such provisions as a condition of enrollment. I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and I understand they are being relied on by Anthem in accepting this application. I understand that any misstatements or failure to report new medical information prior to my effective date may result in a material change to benefits or rates. Any material misrepresentation or significant omission found in this application may result to denial of benefits or rescission or cancellation of my benefits.

Ohio: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statement is guilty of insurance fraud.

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

I give this authorization for and on behalf of any eligible dependents and myself if covered by the Plan. I am acting as their agent and representative.

Your health benefit plan will be administered by one of the following companies based upon the state in which your employer is located:

- In Indiana: Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc.
- In Kentucky: Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Kentucky, Inc.
- In Missouri: Anthem Blue Cross and Blue Shield is the trade name of RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc.
- In Ohio: Anthem Blue Cross and Blue Shield is the trade name of Community Insurance Company.
- In Wisconsin: Anthem Blue Cross and Blue Shield is the trade name of Blue Cross Blue Shield of Wisconsin ("BCBSWI"), which underwrites or administers the PPO and indemnity policies; Compcare Health Services Insurance Corporation ("Compcare"), which underwrites or administers the HMO policies; and Compcare and BCBSWI collectively, which underwrite or administer the POS policies.

Thank you for choosing Anthem Blue Cross and Blue Shield.

Read the TERMS section above carefully before signing. Please review your application for errors or omissions.
 By signing this, I am indicating that I have read and understand the language in the TERMS section of this application and agree to all of its terms.

Applicant signature X	Date
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Policyholder name	Policyholder social security no.
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Section 10. WAIVER OF COVERAGE – For employee and/or any eligible dependent not enrolling.

Check all that apply: Waiving: <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life <input type="checkbox"/> All		
Name of person waiving		Already protected by coverage of: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> None
Employer name	Carrier: <input type="checkbox"/> Anthem (give certificate/policy no.)	<input type="checkbox"/> Other carrier (give name, ID no.)
Check all that apply: Waiving: <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life <input type="checkbox"/> All		
Name of person waiving		Already protected by coverage of: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> None
Employer name	Carrier: <input type="checkbox"/> Anthem (give certificate/policy no.)	<input type="checkbox"/> Other carrier (give name, ID no.)
Check all that apply: Waiving: <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life <input type="checkbox"/> All		
Name of person waiving		Already protected by coverage of: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> None
Employer name	Carrier: <input type="checkbox"/> Anthem (give certificate/policy no.)	<input type="checkbox"/> Other carrier (give name, ID no.)
Check all that apply: Waiving: <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life <input type="checkbox"/> All		
Name of person waiving		Already protected by coverage of: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> None
Employer name	Carrier: <input type="checkbox"/> Anthem (give certificate/policy no.)	<input type="checkbox"/> Other carrier (give name, ID no.)
Check all that apply: Waiving: <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life <input type="checkbox"/> All		
Name of person waiving		Already protected by coverage of: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> None
Employer name	Carrier: <input type="checkbox"/> Anthem (give certificate/policy no.)	<input type="checkbox"/> Other carrier (give name, ID no.)

I certify that I have been given an opportunity to apply for the employer's health benefits plan, and after careful consideration, have decided not to take advantage of this offer. In the event I wish to apply for such benefits hereafter, I may do so, subject to established procedures.

If I am declining enrollment for myself or my dependents (including my spouse) because of other health insurance coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that enrollment is requested within 31 days after other coverage ends. My dependent(s) or I may be subject to pre-existing condition restrictions or waiting periods specified in the group benefit booklet, if a dependent or I are late enrollees. The pre-existing exclusion may not apply to a dependent who is enrolled in the plan prior to his/her 19th Birthday. In addition, if I have a dependent as a result of marriage, birth, adoption or placement for adoption. I may be able to enroll myself and my dependents provided that I request enrollment within 31 days after the marriage, birth, adoption or placement of adoption. I also understand that my dependents and I may enroll under two additional circumstances:

- Either my or my dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- My dependent or I become eligible for a subsidy (state premium assistance program).

In these cases, I may be able to enroll myself and my dependents provided that I request enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

Applicant signature X	Date
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PADUCAH & LOUISVILLE RAILWAY, INC.
PRE-TAX ADVANTAGE ELECTION FORM

Name: _____
(Last) (First) (Middle Initial)

Address: _____
(Street)

(City) (State) (Zip Code)

Employee Identification Number: _____

Please select one of the following:

I authorize my health care premium to be withheld from my payroll check on a pre-tax basis. Select the coverage you would like withheld per month.

	Coverage Per Month	2022
<input type="checkbox"/>	Employee Only	\$175.00
<input type="checkbox"/>	Employee & Spouse	\$200.00
<input type="checkbox"/>	Employee & Child(ren)	\$200.00
<input type="checkbox"/>	Employee, Spouse & Child(ren)	\$225.00

I request to waive health care premium due to other coverage.

(Employee Signature)

Date: _____

Waiver of Group Health Benefits & Notice of Special Enrollment Rights

(Employer Name)

Please complete the following:

Employee Name: _____
(Last) (First) (MI)

Employee Number: _____
(ID, Social Security or employee #)

For the plan year effective ___/___/___ I am waiving coverage for:
(MM/DD/YY)

- Myself
- Spouse/Domestic Partner
- Dependent (s) – Please list names: _____

I am waiving coverage due to:

- My preference not to have coverage
- Coverage under my spouse's/domestic partner's plan – name of carrier: _____
- Other coverage – name of carrier: _____

This other coverage is: Individual COBRA Medicare TRICARE (formerly CHAMPUS)
 Medicaid Employer-Sponsored Group Plan

Special Enrollment Notice and Certification – Please review and sign below if you wish to waive coverage

By signing below, I certify that I have been given an opportunity to apply for coverage for myself and my eligible dependents, if any. I am declining enrollment as indicated above. I understand that I am declining enrollment for myself or my eligible dependents (including my spouse) because of other health insurance or group health plan coverage, I may be able to enroll myself and my eligible dependents in this plan if I lose, or my eligible dependents lose, eligibility for that other coverage (or if the employer stops contributing towards my or my eligible dependents' other coverage).

I understand that I must request enrollment no more than 30 days after the date the other health plan coverage ends (or after the employer stops contributing toward the other coverage). If I do not do so, I will not be able to enroll until my employer's next annual open enrollment period.

In addition, I understand that if I have a newly eligible dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my eligible dependent(s). However, I must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

I understand that in order to request special enrollment or obtain more information, I should contact my group administrator.

Signature of Employee

Date of Signature

Return to your Employee Benefits Group Administrator

Do Not Return to Anthem (AVA 1433)


Paducah and Louisville Railway, Inc: PPO Plan II



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, <https://eoc.anthem.com/eocdps/aso>. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call (833) 578-4443 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$600/person or \$1,200/family for In- Network Providers . \$1,200/person or \$2,400/family for Non- Network Providers .	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible?	Yes. Preventive Care for In- Network Providers . Tier 1 Tier 2 Tier 3 Prescription Drugs for In- Network and Non- Network Providers . Vision for In- Network and Non- Network Providers .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	\$2,400/person or \$4,800/family for In- Network Providers . \$4,200/person or \$8,400/family for Non- Network Providers .	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums , balance-billing charges, health care this plan doesn't cover, and Non- Network Transplants.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider?	Yes, Blue Access. See www.anthem.com or call (833) 578-4443 for a list of network providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan

		pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral .

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	-----none-----
	Specialist visit	20% coinsurance	40% coinsurance	-----none-----
	Preventive care / screening / immunization	No charge	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Costs may vary by site of service.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Costs may vary by site of service.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://www.anthem.com/pharmacyinformation/	Tier 1 - Typically Generic	\$25/prescription, deductible does not apply (retail) and \$40/prescription, deductible does not apply (home delivery)	\$25/prescription, deductible does not apply (retail) and Not covered (home delivery)	For more information, refer to "Essential Drug List" at http://www.anthem.com/pharmacyinformation/ *See Prescription Drug section
	Tier 2 - Typically Preferred Brand & Non-Preferred Generic Drugs	\$35/prescription, deductible does not apply (retail) and \$60/prescription, deductible does not apply (home delivery)	\$35/prescription, deductible does not apply (retail) and Not covered (home delivery)	
	Tier 3 - Typically Non-Preferred Brand and Generic drugs	\$45/prescription, deductible does not apply (retail) and \$80/prescription, deductible does not apply (home delivery)	\$45/prescription, deductible does not apply (retail) and Not covered (home delivery)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	-----none-----
	Physician/surgeon fees	20% coinsurance	40% coinsurance	-----none-----

* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/aso>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	20% coinsurance	Covered as In- Network	-----none-----
	Emergency medical transportation	20% coinsurance	Covered as In- Network	Non-emergency non- network Ambulance Services are limited to \$50,000 per occurrence.
	Urgent care	20% coinsurance	Covered as In- Network	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	150 days/benefit period for Inpatient physical medicine, rehabilitation including day rehabilitation programs and skilled nursing services combined
	Physician/surgeon fees	20% coinsurance	40% coinsurance	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit 20% coinsurance	Office Visit 40% coinsurance	Office Visit -----none-----
		Other Outpatient 20% coinsurance	Other Outpatient 40% coinsurance	Other Outpatient -----none-----
	Inpatient services	20% coinsurance	40% coinsurance	-----none-----
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	100 visits/benefit period for Home Health and Private Duty Nursing combined.
	Rehabilitation services	20% coinsurance	40% coinsurance	Costs may vary by site of service.
	Habilitation services	20% coinsurance	40% coinsurance	*See Therapy Services section.
	Skilled nursing care	20% coinsurance	40% coinsurance	150 days/benefit period for Inpatient physical medicine, rehabilitation including day rehabilitation programs and skilled nursing services combined.
	Durable medical equipment	50% coinsurance	50% coinsurance	*See Durable Medical Equipment Section
	Hospice services	No charge	No charge	-----none-----

* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/aso>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	-----none-----
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other excluded services.)

- | | | |
|---|---|--|
| <ul style="list-style-type: none"> • Acupuncture • Dental care (Adult) • Glasses for a child • Eye exam for a child • Long-term care | <ul style="list-style-type: none"> • Bariatric surgery • Dental care (Pediatric) • Hearing aids • Routine Eye care (Adult) • Routine foot care | <ul style="list-style-type: none"> • Cosmetic surgery • Dental Check-up • Infertility treatment • Weight loss programs |
|---|---|--|

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- | | | |
|--|--|--|
| <ul style="list-style-type: none"> • Most coverage provided outside the United States. See www.bcbsglobalcore.com | <ul style="list-style-type: none"> • Private-duty nursing 100 visits/benefit period combined with Home Health | <ul style="list-style-type: none"> • Spinal Manipulation 20 visits/benefit period |
|--|--|--|

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Insurance, 215 West Main Street, Frankfort, Kentucky 40601, (502) 564-3630, (800) 595-6053, TTY: (800) 648-6056, Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform, or contact Anthem at the number on the back of your ID card. Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact:

ATTN: Grievances and Appeals, P.O. Box 105568, Atlanta GA 30348-5568

Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform

* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/aso>.

Does this plan provide Minimum Essential Coverage? Yes/No

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? Yes/No

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)		Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The plan's overall deductible	\$600	■ The plan's overall deductible	\$600	■ The plan's overall deductible	\$600
■ Specialist coinsurance	20%	■ Specialist coinsurance	20%	■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%	■ Hospital (facility) coinsurance	20%	■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%	■ Other coinsurance	20%	■ Other coinsurance	20%
<p>This EXAMPLE event includes services like:</p> <p>Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>)</p>		<p>This EXAMPLE event includes services like:</p> <p>Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)</p>		<p>This EXAMPLE event includes services like:</p> <p>Emergency room care (<i>including medical supplies</i>) Diagnostic test (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>)</p>	
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
Cost Sharing		Cost Sharing		Cost Sharing	
Deductibles	\$600	Deductibles	\$600	Deductibles	\$600
Copayments	\$0	Copayments	\$1,100	Copayments	\$10
Coinsurance	\$1,800	Coinsurance	\$100	Coinsurance	\$500
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$60	Limits or exclusions	\$20	Limits or exclusions	\$0
The total Peg would pay is	\$2,460	The total Joe would pay is	\$1,820	The total Mia would pay is	\$1,110

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

Language Access Services:

(TTY/TDD: 711)

Albanian (Shqip): Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (833) 578-4443

Amharic (አማርኛ): ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በገና የማግኘት ሙብት አለዎት። አስተርጓሚ ለማናገር (833) 578-4443 ይደውሉ።

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (833) 578-4443.

Armenian (հայերեն): Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (833) 578-4443:

Bassa (Bàsɔ̀ Wùdù): M̄ dyi dyi-diè-djè b̄é b̄édjé b̄á céè-djè nià ke dyí ní, ɔ̀ m̀ò nì dyí-b̄édjèin-djè b̄é m̀ ké gbo-kpá-kpá kè b̄ǎ kpǎ djé m̀ b̄ídjí-wùdùùn b̄ó pídyi. B̄é m̀ ké wuɖu-zìin-nyò d̀ò gbo wùdù ke, d̀á (833) 578-4443.

Bengali (বাংলা): যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (833) 578-4443 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖု (833) 578-4443 သို့ ခေါ်ဆိုပါ။

Chinese (中文): 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(833) 578-4443。

Dinka (Dinka): Na nɔŋ thiëc në ke de yä thorë, ke yin nɔŋ loŋ bē yi kuony ku wër alëu bē gɛɛr yic yin ne thoŋ du ke cin wëu tääuë ke piny. Te kør yin ba jam wënë ran ye thok geryic, ke yin cəl (833) 578-4443.

Dutch (Nederlands): Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (833) 578-4443.

Farsi (فارسي): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه‌ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (833) 578-4443 تماس بگیرید.

Language Access Services:

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (833) 578-4443.

German (Deutsch): Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (833) 578-4443.

Greek (Ελληνικά) Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (833) 578-4443.

Gujarati (ગુજરાતી): જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો (833) 578-4443.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (833) 578-4443.

Hindi (हिंदी): अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें (833) 578-4443 ।

Hmong (White Hmong): Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (833) 578-4443.

Igbo (Igbo): O bụrụ na ị nwere ajuju o bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụsụ gị na akwụghị ugwo o bụla. Ka gị na okowa okwu kwuo okwu, kpọọ (833) 578-4443.

Ilokano (Ilokano): Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (833) 578-4443.

Indonesian (Bahasa Indonesia): Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi (833) 578-4443.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (833) 578-4443

Japanese (日本語): この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(833) 578-4443 にお電話ください。

Language Access Services:

Khmer (ខ្មែរ): បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។
ដើម្បីជ្រកជាមួយអ្នកបកប្រែ សូមហៅ(833) 578-4443 ។

Kirundi (Kirundi): Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (833) 578-4443.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(833) 578-4443 로 문의하십시오.

Lao (ພາສາລາວ): ຖ້າທ່ານມີຄໍາຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ.
ເພື່ອໂອ້ນລັບກັບວ່າມແປພາສາ, ໃຫ້ໂທຫາ (833) 578-4443.

Navajo (Diné): Dii naaltsoos biká'ígíí lahgo bina'idiłkígdgo ná bohónéedzǎ dóó bee ahóót'i' t'áá ni nizaad k'ehjı́ bee nił hodoonih t'áadoo bááh ilínígóó. Ata' halne'ígíí la' bich'ı́' hadeesdzih nínizingo kojı́' hodiılneh (833) 578-4443.

Nepali (नेपाली): यदि यो कागजातबारे तपाईंसँग केही प्रश्नहरू छन् भने, आफ्नै भाषामा निःशुल्क सहयोग तथा जानकारी प्राप्त गर्न पाउने हक तपाईंसँग छ।
दोभाषेसँग कुरा गर्नका लागि, यहाँ कल गर्नुहोस् (833) 578-4443

Oromo (Oromifaa): Sanadi kanaa wajiin walqabaate gaffi kamiyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (833) 578-4443 bilbilla.

Pennsylvania Dutch (Deutsch): Wann du Frooge iwwer selle Document hoscht, du hoscht die Recht um Hilfe un Information zu griege in dei Schprooch mitaus Koscht. Um mit en Iwwersetze zu schwetze, ruff (833) 578-4443 aa.

Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer (833) 578-4443.

Portuguese (Português): Se tiver quaisquer dúvidas acerca deste documento, tem o direito de solicitar ajuda e informações no seu idioma, sem qualquer custo. Para falar com um intérprete, ligue para (833) 578-4443.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਬਾਸੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ(833) 578-4443 ਤੇ ਕਾਲ ਕਰੋ।

Language Access Services:

Romanian (Română): Dacă aveți întrebări referitoare la acest document, aveți dreptul să primiți ajutor și informații în limba dumneavoastră în mod gratuit. Pentru a vă adresa unui interpret, contactați telefonic (833) 578-4443.

Russian (Русский): Если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (833) 578-4443.

Samoan (Samoa): Afai e iai ni ou fesili e uiga i lenei tusi, e iai lou 'aia e maua se fesoasoani ma faamatalaga i lou lava gagana e aunoa ma se todogi. Ina ia talanoa i se tagata faaliliu, vili (833) 578-4443.

Serbian (Srpski): Ukoliko imate bilo kakvih pitanja u vezi sa ovim dokumentom, imate pravo da dobijete pomoć i informacije na vašem jeziku bez ikakvih troškova. Za razgovor sa prevodiocem, pozovite (833) 578-4443.

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (833) 578-4443.

Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (833) 578-4443.

Thai (ไทย): หากท่านมีคำถามใดๆ เกี่ยวกับเอกสารฉบับนี้ ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่านโดยไม่มีค่าใช้จ่าย โดยโทร (833) 578-4443 เพื่อพูดคุยกับล่าม

Ukrainian (Українська): якщо у вас виникають запитання з приводу цього документа, ви маєте право безкоштовно отримати допомогу й інформацію вашою рідною мовою. Щоб отримати послуги перекладача, зателефонуйте за номером (833) 578-4443.

Urdu (اردو): اگر اس دستاویز کے بارے میں آپ کا کوئی سوال ہے، تو آپ کو مدد اور اپنی زبان میں مفت معلومات حاصل کرنے کا حق حاصل ہے۔ کسی مترجم سے بات کرنے کے لئے، (833) 578-4443 پر کال کریں۔

Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (833) 578-4443.

(Yiddish) (אידיש): אויב איר האט שאלות וועגן דעם דאקומענט, האט איר די רעכט צו באקומען דעם אינפארמאציע אין אייער שפראך אהן קיין פרייז. צו רעדן צו אן איבערזעצער, רופט (833) 578-4443.

Yoruba (Yorùbá): Tí o bá ní èyíkéyí ìbèrè nípa àkọsílẹ̀ yí, o ní ètọ́ láti gba ìrànwọ́ àti ìwífún ní èdè rẹ̀ lẹ́fẹ́. Bá wa ògbùfọ̀ kan sọrọ̀, pe (833) 578-4443.

Language Access Services:

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

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)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of October 15, 2021. Contact your State for more information on eligibility –

ALABAMA Medicaid	CALIFORNIA Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov
ALASKA Medicaid	COLORADO Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS Medicaid	FLORIDA Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html Phone: 1-877-357-3268

<p align="center">GEORGIA Medicaid</p> <p>Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131</p>	<p align="center">MASSACHUSETTS Medicaid and CHIP</p> <p>Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840</p>
<p align="center">INDIANA Medicaid</p> <p>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</p>	<p align="center">MINNESOTA Medicaid</p> <p>Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739</p>
<p align="center">IOWA Medicaid and CHIP (Hawki)</p> <p>Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562</p>	<p align="center">MISSOURI Medicaid</p> <p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>
<p align="center">KANSAS Medicaid</p> <p>Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884</p>	<p align="center">MONTANA Medicaid</p> <p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084</p>
<p align="center">KENTUCKY Medicaid</p> <p>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: KIHIPPPROGRAM@ky.gov</p> <p>KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718</p> <p>Kentucky Medicaid Website: https://chfs.ky.gov</p>	<p align="center">NEBRASKA Medicaid</p> <p>Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178</p>
<p align="center">LOUISIANA Medicaid</p> <p>Website: www.medicicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>	<p align="center">NEVADA Medicaid</p> <p>Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900</p>
<p align="center">MAINE Medicaid</p> <p>Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711</p> <p>Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711</p>	<p align="center">NEW HAMPSHIRE Medicaid</p> <p>Website: https://www.dhhs.nh.gov/oi/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218</p>

<p align="center">NEW JERSEY Medicaid and CHIP</p> <p>Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710</p>	<p align="center">SOUTH DAKOTA Medicaid</p> <p>Website: http://dss.sd.gov Phone: 1-888-828-0059</p>
<p align="center">NEW YORK Medicaid</p> <p>Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831</p>	<p align="center">TEXAS Medicaid</p> <p>Website: http://gethipptexas.com/ Phone: 1-800-440-0493</p>
<p align="center">NORTH CAROLINA Medicaid</p> <p>Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100</p>	<p align="center">UTAH Medicaid and CHIP</p> <p>Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669</p>
<p align="center">NORTH DAKOTA Medicaid</p> <p>Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825</p>	<p align="center">VERMONT Medicaid</p> <p>Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427</p>
<p align="center">OKLAHOMA Medicaid and CHIP</p> <p>Website: http://www.insureoklahoma.org Phone: 1-888-365-3742</p>	<p align="center">VIRGINIA Medicaid and CHIP</p> <p>Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924</p>
<p align="center">OREGON Medicaid</p> <p>Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075</p>	<p align="center">WASHINGTON Medicaid</p> <p>Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022</p>
<p align="center">PENNSYLVANIA Medicaid</p> <p>Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462</p>	<p align="center">WEST VIRGINIA Medicaid</p> <p>Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)</p>
<p align="center">RHODE ISLAND Medicaid and CHIP</p>	<p align="center">WISCONSIN Medicaid and CHIP</p>
<p>Website: http://www.cohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)</p>	<p>Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002</p>
<p align="center">SOUTH CAROLINA Medicaid</p> <p>Website: https://www.scdhhs.gov Phone: 1-888-549-0820</p>	<p align="center">WYOMING Medicaid</p> <p>Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269</p>

To see if any other states have added a premium assistance program since October 15, 2021, 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 ebbsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

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

2021 COMPLIANCE NOTICES

Women's Health and Cancer Rights Act (WHCRA) of 1998

If you have had a mastectomy or expect to have one, you may be entitled to special rights under the Women's Health and Cancer Rights Act of 1998 (WHCRA).

Under WHCRA, group health plans, insurance companies and health maintenance organizations (HMOs) offering mastectomy coverage also must provide coverage for certain services relating to the mastectomy in a manner determined in consultation with your attending physician and you. This required coverage includes:

- all stages of reconstruction of the breast on which the mastectomy was performed,
- surgery and reconstruction of the other breast to produce a symmetrical appearance,
- prostheses and treatment of physical complications of the mastectomy, including lymphedema.

Health plans must cover mastectomy related benefits in a manner determined with the attending physician and the patient. Coverage for mastectomy related care may be subject to deductible and coinsurance amounts that are consistent with other benefits covered by the plan.

Privacy Notice

Paducah and Louisville Railway has issued a Health Plan Privacy Notice that describes how the Plan uses and discloses protected health information (PHI). You can obtain a copy of the Paducah and Louisville Railway Plan Privacy Notice upon written request to the Human Resource Department.

Special Enrollment

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 and 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.

Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or a State health insurance ("SCHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify the company and enroll in the plan.

Patient Protection Model Disclosure Notice

Anthem generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Anthem at www.anthem.com or the customer service number on the back of your identification card.

You do not need prior authorization from Anthem or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Anthem at www.anthem.com or the customer service number on the back of your identification card.



New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Benefits Department, 200 Clark Street, Paducah KY 42003

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

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name Paducah & Louisville Railway, Inc		4. Employer Identification Number (EIN) 61-1093024	
5. Employer address 200 Clark Street		6. Employer phone number 270-444-4304	
7. City Paducah	8. State KY	9. ZIP code 42003	
10. Who can we contact about employee health coverage at this job? Karen Tucker			
11. Phone number (if different from above)		12. Email address ktucker@palrr.com	

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

- As your employer, we offer a health plan to:

All employees. Eligible employees are:

Some employees. Eligible employees are:

- With respect to dependents:

We do offer coverage. Eligible dependents are:

Subscriber's spouse, Subscriber of Subscriber's spouse's children, including natural children, stepchildren, newborn and legally adopted children, children for whom the Subscriber or Subscriber's spouse is legal guardian, or as otherwise required by law including those covered by a "Qualified Medical Child Support Order"

We do not offer coverage.

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

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

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

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

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

Yes (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

No (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

Yes (Go to question 15) No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? \$ 175.00

b. How often? Weekly Every 2 weeks Twice a month Monthly Quarterly Yearly

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

16. What change will the employer make for the new plan year? _____

Employer won't offer health coverage

Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? \$ _____

b. How often? Weekly Every 2 weeks Twice a month Monthly Quarterly Yearly

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

YOUR HEALTH CARE COVERAGE AND CHANGES IN YOUR FAMILY

You must inform the BENEFITS DEPARTMENT if you have changes to your family.

NEW SPOUSE: You have **31** days from the marriage date to add a new spouse to your health care coverage.

BIRTH/ADOPTION OF A CHILD: You have **31** days from the birth/adoption date to add a new child to your health care coverage. Do **not** wait until you have the child's social security number to return your form. Return the form promptly and contact the Benefits Department again once you receive the social security number.

New dependents are **not** automatically covered by our health plan and **will not** be covered by our health plan **until you add them as dependents to your healthcare form**. After **31** days, new dependents cannot be added to your health care coverage until open enrollment time. Coverage for dependants added at open enrollment will begin on January 1 of the next year.

DIVORCE OR LEGAL SEPARATION: You should contact the Benefits Department to remove a spouse or dependents immediately following the date of divorce or legal separation. You cannot eliminate coverage for a spouse or dependents prior to a pending divorce.

ENROLLMENT OR DISENROLLMENT UNDER ANOTHER HEALTH PLAN: You must notify the Benefits Department if you or your spouse or dependents are enrolled or un-enrolled in another health plan.

ENROLLMENT OR DISENROLLMENT UNDER MEDICARE: You must notify the Benefits Department if you or your spouse or dependents are enrolled or un-enrolled in Medicare.

AWARD OF RRB DISABILITY BENEFITS: If you are awarded disability benefits from the RRB, you must notify the Benefits Department immediately upon receiving your notice.

BENEFITS DEPARTMENT:

Sherri Goodwin 270-444-4338 (sgoodwin@palrr.com)

Alayna Stinnett 270-444-4330 (astinnett@palrr.com)

Karen Tucker 270-444-4304 (kmtucker@palrr.com)

200 Clark Street

Paducah, KY 42003

Fax: 270-444-4364

Patient Protection Disclosure

Anthem generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Anthem at www.anthem.com and select provider search or call customer service at 888-650-4047.

You do not need prior authorization from Anthem or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Anthem at www.anthem.com and select provider search or call customer service at 888-650-4047.

Important Notice from Paducah & Louisville Railway About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

- 1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
- 2. It has been determined that the prescription drug coverage offered by the Paducah & Louisville Railway is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

CMS Form 10182-CC

Updated April 1, 2011

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Paducah & Louisville Railway coverage will not be affected. If you choose to keep your Paducah & Louisville Railway coverage should you elect Medicare Part D coverage, it may supplement your current prescription drug coverage. For more information, See pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at <http://www.cms.hhs.gov/CreditableCoverage/>), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current Paducah & Louisville Railway coverage, be aware that you and your dependents will not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. Note: You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Paducah & Louisville Railway changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov

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- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: October 1, 2021

Name of Entity/Sender: Paducah & Louisville Railway

Contact--Position/Office: Karen Tucker, Employee Benefits Manager

Address: 200 Clark Street, Paducah, Ky. 42003

Phone Number: 270-444-4304

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The cost of your specialty medication is changing.

Action needed before your next fill to pay \$0 out of pocket

[PATIENT NAME]

[ADDRESS]

[CITY, STATE, ZIP]

Dear [PATIENT NAME],

IngenioRx Specialty® is offering a program that can save you money and reduce your out-of-pocket cost for select specialty medications to \$0 effective **[Month Day, Year]**.

Pay \$0 with Cost Relief

The Cost Relief program allows you to get select specialty medications for \$0 out of-pocket when you fill through IngenioRx Specialty®.

The Cost Relief program works with you and the drug manufacturers to obtain copay assistance¹ and manages enrollment and renewals for copay programs on your behalf. Even if there is no copay assistance for your medication, your out-of-pocket cost will be \$0 for your covered specialty medication(s) under Cost Relief.

Enroll before your next fill to avoid paying more

- Step One: The first step of the enrollment process is already complete, and your member information is on file with IngenioRx Specialty®.
- Step Two: Call IngenioRx Specialty at 1-877-638-4008 before your next fill to complete your registration for Cost Relief and copay assistance if available from drug manufacturers.

You must speak with a IngenioRx Specialty representative to complete step two and become fully enrolled to avoid paying more for your medication(s).

Even if you currently have copay assistance or take a medication that does not have copay assistance available, you still need to speak with a IngenioRx representative. They will also attempt to reach you by phone to confirm your enrollment.

If you do not return the call, choose to opt-out of the program, or if you do not affirmatively enroll in available copay assistance programs as required by a manufacturer, you will be responsible for 30% to 45% of the cost of your preferred or non-preferred specialty medication(s), respectively. If you have any questions about the Cost Relief program, call IngenioRx Specialty at 1-877-638-4008, Monday through Friday, from 8 a.m. to 8 p.m. ET.



Please note: At the time of this mailing, IngenioRx Specialty® may not have information on your benefit plan election for the upcoming plan year. If your benefit plan selection for the upcoming plan year does not include Cost Relief or, should you change your plan election at any time to a plan that does not include Cost Relief you will not be eligible to participate in the program. For questions about which plans are eligible for the Cost Relief program, please contact your plan benefit office.

Sincerely,

[IngenioRxSign-off]

Please note: Some medications in the program are listed as an “essential health benefit,” which allows your out-of-pocket cost to apply to your out-of-pocket maximum. Many specialty medications are considered “non-essential health benefits.”^{2,3} For medications that are non-essential health benefits, amounts paid by you, a manufacturer or a plan sponsor will not apply to your out-of-pocket maximum.⁴

1. Eligibility for third-party copay assistance program is dependent on the applicable terms and conditions required by that particular program and are subject to change. Copay assistance program may not be used with any government payor plan.
2. A self-funded Plan may define the items and services that qualify as “essential health benefits” by referencing any definition authorized by the U.S. Department of Health and Human Services, including any available state benchmark plan. Your Plan utilizes the Utah Essential Health Benefit Benchmark Plan.
3. There’s an exception process to decide if a medication that’s not an “essential health benefit” is medically necessary for a particular plan member.
4. The out-of-pocket maximum is the total amount you must pay in a plan year for certain covered services called “essential health benefits.” Once the specified out-of-pocket limit is reached, your health plan will pay 100 percent of the cost of these covered services. More information on the out-of-pocket limit is available in your plan benefit materials. Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.



Cost Relief: connecting your employees with greater Rx savings

Bringing your employees \$0 cost share for specialty drugs

Specialty drugs bring new hope in the fight against a number of health problems – but they often come at a high cost. We are working to help hold down those costs, with a program that could mean \$0 copays on certain specialty drugs for your employees.

How Cost Relief works to save money

With Cost Relief, employers and employees can access allocated – but currently unused – manufacturer copay assistance program funds. This allows us to reduce the plan paid portion for certain specialty drugs. **Without this program, approximately 75% in manufacturer copay assistance dollars went unused in 2020.**³

Our comprehensive, proactive outreach program educates employees and helps them with program enrollment. Letters and phone calls will help ensure that all eligible employees are educated on the assistance available to them, and how they can stay enrolled in their respective copay assistance program.

- **Virtually all specialty drugs** are included as part of this program
- Employers can also access the program's **robust reporting and analytics**, including utilization and outreach metrics

Please note: Cost Relief is not recommended for high deductible health plans with HSA plan designs nor first-dollar HRA plans.⁴ Plan exclusions: Cost Plus, Minimum Premium, FEP, MedSupp, Labor & Trust and Refunding Fully Insured Groups

Learn more, so your employees can save more

To learn more about the program or request an opportunity and savings analysis, contact your plan representative.

We're here to help.



1. Members must enroll in the program and cost share could vary dependent on member enrollment. Members who do not wish to participate in this program can opt out and will be responsible for the full amount of the cost share for their specialty drug. Cost shares for any non-essential drug do not count towards plan deductible nor out-of-pocket limit. Employer group should consult legal advisor in considering this benefit feature.
2. Based on our BOB claims data for copay plans, 2021.
3. 2020 Internal analysis of Anthem's commercial book of business.
4. High deductible health plans with HSA may have conflict with IRS guidelines governing this plan type. Not recommended for First Dollar HRA plan designs because the first fill of a specialty drug will take member cost share from the member's HRA account.
Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. In Connecticut: Anthem Health Plans, Inc. In Georgia: Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. HMO plans are administered by Anthem Health Plans of New Hampshire, Inc. and underwritten by Matthew Thornton Health Plan, Inc. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI), underwrites or administers PPO and indemnity policies and underwrites the out of network benefits in POS policies offered by CompCare Health Services Insurance Corporation (CompCare) or Wisconsin Collaborative Insurance Corporation (WCIC). CompCare underwrites or administers HMO or POS policies; WCIC underwrites or administers Well Priority HMO or POS policies. Independent licensees of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.