COMMONWEALTH OF KENTUCKY

COMMONWEALTH ENHANCED
SUMMARY PLAN DESCRIPTION

GROUP NUMBERS: P5941, P6070 AND P6077

EFFECTIVE JANUARY 1, 2006

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PLAN DESCRIPTION INFORMATION

1. Proper Name of *Plan*: Kentucky Employees Health Plan

   Common Name of *Plan*: Commonwealth of Kentucky

2. Plan Sponsor and *Employer*: Commonwealth of Kentucky
   Personnel Cabinet, Department for Employee Insurance
   200 Fair Oaks Lane
   Suite 501
   Frankfort, Kentucky 40601

3. Plan Administrator and Named Fiduciary:

   Commonwealth of Kentucky
   Personnel Cabinet, Department for Employee Insurance
   200 Fair Oaks Lane
   Suite 501
   Frankfort, Kentucky 40601

4. *Employer* Identification Number: 61-0600439.

5. The *Plan* provides medical benefits for participating *employees* and their enrolled *dependents*.

6. *Plan* benefits described in this booklet are effective January 1, 2006.

7. The *Plan year* is January 1 through December 31 of each year.

8. Service of legal process may be served upon the Plan Administrator as shown above or the following agent for service of legal process:

   Commonwealth of Kentucky
   Personnel Cabinet, Office of Legal Services
   200 Fair Oaks Lane
   Suite 516
   Frankfort, Kentucky 40601

9. The *Plan Manager* is responsible for performing certain delegated administrative duties, including the processing of *claims*. The *Plan Manager* and Claim Fiduciary is:

   Humana Insurance Company
   500 West Main Street
   Louisville, Kentucky 40202
   Telephone: 1-877-597-7474

Plan Description Information Continued

10. This is a self-insured health benefit *plan*. The cost of the *Plan* is paid with contributions shared by the *employer* and *employee*. Benefits under the *Plan* are provided from the general assets of the *employer* and are used to fund payment of covered *claims* under the *Plan* plus administrative expenses. Please see *your employer* for the method of calculating contributions and the funding mechanism used for the accumulation of assets through which benefits are provided under this *Plan*.

11. Each *employee* of the *employer* who participates in the *Plan* receives a *Summary Plan Description*, which is this booklet. This booklet will be available through MyHumana.com for *employees*. It contains information regarding eligibility requirements, termination provisions, a description of the benefits provided and other *Plan* information.

12. The *Plan* benefits and/or contributions may be modified or amended from time to time, or may be terminated at any time by the Plan Sponsor. Significant changes to the *Plan*, including termination, will be communicated to participants as required by applicable law.

13. Upon termination of the *Plan*, the rights of the participants to benefits are limited to *claims* incurred and payable by the *Plan* up to the date of termination. *Plan* assets, if any, will be allocated and disposed of for the exclusive benefit of the participating *employees* and their *dependents* covered by the *Plan*, except that any taxes and administration expenses may be made from the *Plan* assets.

14. The *Plan* does not constitute a contract between the *employer* and any *covered person* and will not be considered as an inducement or condition of the employment of any *employee*. Nothing in the *Plan* will give any *employee* the right to be retained in the service of the *employer*, or for the *employer* to discharge any *employee* at any time.

15. This *Plan* is not in lieu of and does not affect any requirement for coverage by Workers' Compensation insurance.

16. This *Plan* is included in the Commonwealth of Kentucky Flexible Benefits Plan. A Cafeteria Plan created pursuant to the Internal Revenue Code Subsection 125.

YOUR RIGHTS AND RESPONSIBILITIES

As a Humana *plan member, you* have the right to:	***You* also have the responsibility to:**
• Be provided with information about the Humana *plan*, its *services* and benefits, its *providers*, and *your member* rights and responsibilities.	• Give the Humana *Plan* and *your* health care *provider* complete and accurate information needed in order to care for *you*.
• Privacy and confidentiality regarding *your* medical care and records. Records pertaining to *your* health care will not be released without *your* or *your* authorized representative's written permission, except as required by law.	• Read and be aware of all material distributed by the *plan* explaining policies and procedures regarding *services* and benefits. • Obtain and carefully consider all information *you* may need or desire in order to give informed consent for a procedure or treatment.
• Discuss *your* medical record with *your physician*, and receive upon request a copy of that record.	• Follow the treatment plan agreed on with *your* health care *provider*, and to weigh the potential consequences of any refusal to observe those instructions or recommendations.
• Be informed of *your* diagnosis, treatment choices, including non-treatment, and prognosis in terms *you* can reasonably expect to understand, and to participate in decision-making about *your* health care and treatment plan.	• Be considerate and cooperative in dealing with the *plan providers* and to respect the rights of fellow *plan members*.
• Have a candid discussion with *your* practitioner about appropriate or *medically necessary* treatment options for *your* conditions, regardless of cost or benefit coverage.	• Schedule appointments, arrive on time for scheduled visits, and notify *your* health care *provider* if *you* must cancel or be late for a scheduled appointment. • Express opinions, concerns, or complaints in a constructive manner.
• Expect reasonable access to *medically necessary* health care *services* regardless of race, national origin, religion, physical abilities, or source payment.	• Notify the Plan Sponsor in writing if *you* move or change *your* address or phone number, even if these changes are only temporary.
• File a formal complaint, as outlined in the *plan's* grievance procedure, and to expect a response to that complaint within a reasonable period of time.	• Pay all *copayments*, coinsurance and/or *premiums* by the date when they are due.
• Be treated with courtesy and respect, with appreciation for *your* dignity and protection of *your* right to privacy.	• Be honest and open with *your physician* and report unexpected changes in *your* condition in a timely fashion.
• Make recommendations regarding the *Plan's* "rights and responsibilities" policies.	• Follow health care facility rules and regulations affecting patient care and conduct.

As a Humana *plan member, you* have the right to:	***You* also have the responsibility to:**
• Receive Humana's Notice of Privacy Practices. • Expect *your* personal information to be kept secure and used appropriately for payment and health plan operations. • Expect Humana to adhere to all privacy and confidentiality policies and procedures. • Expect the following activities concerning *your* personal information: ➢ Request an accounting of disclosures of personal health information disclosed for reasons outside of payment and health plan operations. ➢ Receive an authorization form for any proposed use of *your* personal health information outside of routine payment and health plan operations. ➢ Request an alternate form of communication of personal health information if the release of a portion or all of the information could endanger life or health. ➢ Right to complain regarding an alleged breach of privacy. ➢ Right to agree or object regarding Humana's intent to release *your* personal information outside of payment or health plan operations. ➢ Right to request an amendment or correction of *your* personal information to a designated record created by Humana. ➢ Right to request access to inspect and copy information.	• Carry *your* Humana identification card with *you* at all times and use it while enrolled in the Humana *Plan*.

As a Humana *plan member, you* have the right to: • Expect the following activities concerning *your* personal information continued: ➢ Right to request Humana to restrict the use and disclosure of *your* personal information and the right to terminate the restriction request.	

SCHEDULE OF BENEFITS

AN IMPORTANT MESSAGE ABOUT YOUR PLAN

Services are subject to all provisions of the *Plan*, including the limitations and exclusions.

Italicized terms within the text are defined in the Definitions section of this booklet.

PRECERTIFICATION

Precertification will be performed by a *Plan Manager*. Refer to *your* ID card for the appropriate phone number for *your* provider to call for *precertification*.

The following benefits require *precertification*:

SERVICES REQUIRING PRECERTIFICATION

The *Plan Manager* must be notified prior to the following *services* being rendered. If these *services* are not *precertified*, benefits will not be covered. The penalty does not apply to the deductible or out-of-pocket maximums.

Inpatient Hospitalizations (The *Plan Manager* must be notified at least 7 days in advance. If the admission is on an *emergency* basis, the *Plan Manager* must be notified within 48 hours or the first business day following admission, whichever is later.)

- Obstetrical hospitalizations
- All medical or surgical admissions
- Documentation may be requested for such procedures as:
  - Back Surgery including Discetomy, Laminectomy and Lumbar Fusion
  - Lung Volume Reduction Surgery
  - Unlisted Laparoscopic procedure of the abdomen
  - Weight Loss Surgery

Outpatient Medical/Surgical Procedures

- Sleep studies

Therapy Services

- Skilled nursing facility
- Rehab facilities
- Physical therapy (above 18 visits)
- Speech therapy (above 18 visits)
- Occupational therapy (above 18 visits)

Home Health (not following hospitalization)

Durable Medical Equipment (DME)

- Durable medical equipment (over $500)
- Continuous positive airway pressure (CPAP)
- Intermittent assist device w/BIPAP
- Miscellaneous DME Code: E3199

SERVICES REQUIRING PRECERTIFICATION

Imaging and Radiology (non-emergent, outpatient)

- CT/MRI/MRA
- PET Scan

All *Mental Disorder,* Alcoholism and Chemical Dependency Services

Pharmaceuticals and Injectables (*services* rendered in a physician's office)

- Aglucerase injection (Ceredase) and Imiglucerase for injection (Cerezyme)
- Growth hormone therapy
- Biologics except when used as chemotherapeutic agents
- Anti-TNF drugs: Used for Arthritis, Colitis, Psoriasis, etc.
  - Amevive (alefacept)
  - Enbrel (entanercept)
  - Humira (adalimumab)
  - Kineret (anakinra)
  - Raptiva (efalizumab)
  - Remicade (infliximab)
- Support biologics
  - Erythropoetin
  - Granulocyte colony stimulating factor
  - Kepivance (palifermin)
- Other biologics
  - Amevive (alefacept)
  - Pulmozyme (dornase alfa)
  - Synogis (palivizumab)
  - Xolair

Cosmetic or Reconstructive Services Review – These examples are not intended to represent all possible cosmetic procedures.

- Amniotic membrane transplantation (AMT) in the eye
- Blepharoplasty: Lower eyelid
- Blepharoplasty: Upper eyelid
- Blepharoplasty: Repair of Blepharoptosis
- Breast: Capsulectomy
- Breast: Mammaplasty augmentation or mammaplasty augmentation with implant
- Breast: Mastectomy gynecomastia
- Breast: Mastectomy partial, simple complete or subcutaneous (cancer diagnosis only)
- Breast: Mastopexy (cancer diagnosis only)
- Breast: Following mastopexy (cancer diagnosis only)
  - Delayed insertion of breat prosthesis
  - Immediate insertion of breast prosthesis
  - Following mastopexy (cancer diagnosis only)
- Breast: Reduction mammaplasty
- Breast: Removal of mammary implant or material
- Breast: Remove tissue expander (caner diagnosis only)
- Breast: Replace tissue expander with prosthesis (cancer diagnosis only)
- Breast: Nipple/areola reconstruction (cancer diagnosis only)
- Breast: Correction of inverted nipples (cancer diagnosis only)

Schedule of Benefits Continued

SERVICES REQUIRING PRECERTIFICATION

Cosmetic or Reconstructive Services Review Continued

- Breast: Reconstruction (cancer diagnosis only)
- Breast: Revision of reconstructed breast (cancer diagnosis only)
- Breast tattooing (cancer diagnosis only)
- Cranial banding
- Genioplasty
- Panniculectomy
- Penile: Revascularization
- Penile: Venous occlusive procedure
- Penile: Implants, non-inflatable or inflatable
- Penile: Removal or replacement of non-inflatable
- Penile Prosthesis: Insertion or removal of inflatable penile prosthesis
- Scar revision
- Sclerotherapy
- Septoplasty
- Tissue expander-insertion other than breast
- UPPP (Uvulopalatopharynogoplasty)/LAUP

Dental Procedures

- Orthognathic surgery
  - Osteotomy of the jaw
  - Le Fort I osteotomy
  - Le Fort III osteotomy
  - Osteotomy of jaw sagittal split
  - Osteotomy: Maxilla sagittal
- Temporomandibular joint surgeries (TMJ)
  - Arthroplasty
  - Arthrotomy
  - Arthroscopy
  - Condylectomy
  - Coronoidectomy
- Temporomandibular joint (TMJ) splint (orthotic appliance)

Experimental/Investigational – These examples are not intended to represent all experimental therapies.

- Angel wing device for atrial septal defect closure
- Artificial liver device
- Body Sterotactic Radiotherapy (SRT)
- Breast Ductal Lavage
- Canalith Repositioning Procedures (CRP)
- CardiaRisk
- Cardiointegram
- Cingulotomy for Obsessive-Compulsive Disorder
- Coronary Gene Therapy
- Defecography
- Extracorporeal Shockwave Therapy (ESWT) for Plantar Fasciitis

Schedule of Benefits Continued

SERVICES REQUIRING PRECERTIFICATION
Experimental/Investigational Continued
Functional Electrical Stimulation (FES)
Gallbladder Lithotripsy (biliary)
Gastric Pacing
Gastric Reflux Devices (Bard Enoscopic Suturing System, Stretta System)
Hepatocyte Transplantation (HT)
Intradiscal Electrothermal Annuloplasty (IDET)
Islet Cell Transplantation (ICTx)
Orthrotripsy (for Plantar Fasciitis)
Prosorba Column except for Treatment of Rheumatoid Arthritis
Radiofrequency Ablation (RFA) of Hepatic Tumors
ReliefBand
Reveal Insertable Loop Recorder (ILR)
TheraSphere
Thermography
Transarterial Chemoembolization (TACE)
Transmyocardial Revascularization (TMR)
Videofluroscopy of the Spine (Motion X-rays)

PREFERRED PROVIDER AND FACILITY PLAN OPTION

Agreements have been made with certain *providers* and facilities of health care called Preferred *Providers* (PAR *providers*) and Preferred Facilities (PAR facilities). *You* may select any *provider* to provide *your* medical care.

The Plan Administrator will automatically provide, without charge, information to *you* about how *you* can access a directory of PAR *Providers*, appropriate to *your service area*. The PAR *provider* directory will be available either in hard copy as a separate document, or in electronic format. Because health care *providers* enter and exit networks unpredictably, the *Plan Manager* can be contacted for network *provider* verification.

If *you* choose to receive *your* medical care from a Preferred *Provider*, *services* are payable as shown on the Schedule of Benefits. Office exams are subject to a $10 *copayment* per visit as shown on the Schedule of Benefits. The *copayment* does not apply to the *coinsurance* or *out-of-pocket limits* shown on the Schedule of Benefits. C*opayment* includes all *services* performed on the same day/same site as office visit.

If *you* choose to receive *your* medical care from a Preferred Facility, *covered expenses* are payable as shown on the Schedule of Benefits.

Covered expenses are payable on a *maximum allowable fee* basis. Any applicable *copayment* or penalty does not apply to the *deductible* or *out-of-pocket limits* shown on the Schedule of Benefits. *Copayments* will continue to be the responsibility of the *covered person.*

Professional *services* rendered by a facility based Non-PAR *Physician* but performed at a PAR facility, are automatically paid at the PAR level of benefits.

This schedule provides a brief overview of *Plan* benefits and is not a complete description. Refer to the text for a detailed description of *your Plan* benefits.

GET HEALTHY PROGRAM

The *Plan Manager* will offer the **Get Healthy** program which identifies *your* specific health risks using information *you* provide by completing a simple questionnaire (the Personal Health Analysis (PHA), also known as the Health Risk assessment). A detailed wellness report will inform *you* of the results. Logon to kyhealthplan.humana.com to take the Personal Health Analysis. After *you* complete the PHA, *you* can call 1-877- KYSPIRIT (1-877-597-7474) to consult with a Gordian Health Coach. *Your* Health Coach will explain *your* wellness report and provide information and suggestions on steps *you* can take to change *your* health habits and work towards a healthier lifestyle.

Schedule of Benefits Continued

MEDICAL DEDUCTIBLE AND COINSURANCE INFORMATION		
Lifetime Maximum	Unlimited	
BENEFIT	**PAR PROVIDER (IN-NETWORK)**	**NON-PAR PROVIDER (OUT-OF-NETWORK)**
Deductible: Individual Family	 $250 $500 aggregate	 $ 500 $1,000 aggregate
Coinsurance	80% (*you* pay 20%)	60% (*you* pay 40%)
Out-of-pocket limit: (Includes Deductible) Individual Family	 $1,250 $2,500	 $2,500 $5,000

When the amount of combined *covered expenses* paid by *you* and/or all *your* covered *dependents* satisfy the *out-of-pocket limit*s, including the *deductible* as shown on the Schedule of Benefits, the *Plan* will pay 100% of *covered expenses* for the remainder of the *calendar year*, unless specifically indicated, subject to any *calendar year* maximums of the *Plan*. *Copayments* will continue to be the responsibility of the *covered person.*

If *you* and *your* covered *dependents* use a combination of *PAR* and *Non-PAR providers*, the PAR and Non-PAR *deductible* amounts will reduce each other.

If *you* and *your* covered *dependents* use a combination of *PAR* and *Non-PAR providers*, the PAR and Non-PAR out-of-pocket amounts will reduce each other.

If *you* or *your* covered *dependents* use a *Non-PAR provider*, the *Plan Manager's* reimbursement will be payable on a *maximum allowable fee* basis. Any amounts above the *maximum allowable fee* will be the *member's* responsibility and will NOT apply to the *out-of-pocket limit*.

Schedule of Benefits Continued

MEDICAL COVERED EXPENSES		
BENEFIT	**PAR PROVIDER (IN-NETWORK)**	**NON-PAR PROVIDER* (OUT-OF-NETWORK)**
Inpatient Hospital	Subject to *deductible* and *coinsurance*.	Subject to *deductible* and *coinsurance*.
***Outpatient* Facility**		
Outpatient Hospital	Subject to *deductible* and *coinsurance*.	Subject to *deductible* and *coinsurance*.
Outpatient Diagnostic X-ray and Lab	Subject to a $10 *copayment* per provider, per *member* site, then payable at 100%.	Subject to *deductible* and *coinsurance*.
Pre-admission Testing	Subject to a $10 *copayment* per visit, then payable at 100%.	Subject to *deductible* and *coinsurance*.
Emergency Room	Subject to a $50 *copayment* per visit, then *payable* at 80% *coinsurance*.	Subject to a $50 *copayment* per visit, then *payable* at 60% *coinsurance*.
Emergency Room *Physician*	Subject to *coinsurance*.	Subject to *coinsurance*.
	True *emergency* care provided by a *Non-PAR provider* will be covered at the *PAR provider* level. The *emergency* room *copayment* will be waived if *you* are admitted.	
Free Standing Surgical Facility	Subject to *deductible* and *coinsurance*.	Subject to *deductible* and *coinsurance*.
Urgent Care Facility	Subject to a $20 *copayment* per visit, then payable at 100%.	Subject to *deductible* and *coinsurance*.
Qualified Practitioner (Office Visits)	Subject to a $10 *copayment* per visit, then payable at 100%.	Subject to *deductible* and *coinsurance*.
Qualified Practitioner (Other than Office Visits)	Subject to *deductible* and *coinsurance*.	Subject to *deductible* and *coinsurance*.
Injection, other than routine	Subject to a $10 *copayment* per visit, then payable at 100%.	Subject to *deductible* and *coinsurance*.

*Non-PAR Providers are subject to *balance billing.*

Schedule of Benefits Continued

MEDICAL COVERED EXPENSES		
BENEFIT	**PAR PROVIDER (IN-NETWORK)**	**NON-PAR PROVIDER* (OUT-OF-NETWORK)**
Diagnostic X-ray and Lab		
Office setting (same site/same day as office visit)	Payable at 100%, after office visit *copayment*.	Subject to *deductible* and *coinsurance*.
Independent Lab	Payable at 100%.	Subject to *deductible* and *coinsurance*.
Outpatient X-ray	Subject to a $10 *copayment* per visit, then payable at 100%.	Subject to *deductible* and *coinsurance*.
Inpatient setting	Subject to *deductible* and *coinsurance*.	Subject to *deductible* and *coinsurance*.
Emergency Room setting	Subject to *coinsurance,* after *emergency* room *copayment.*	Subject to *coinsurance,* after *emergency* room *copayment e*
Anesthesia and Surgery Services (including Oral Surgery)		
Office or Clinic Setting	Subject to a $10 *copayment* per visit, then payable at 100%.	Subject to *deductible* and *coinsurance*.
Inpatient or *Outpatient* Setting	Subject to *deductible* and *coinsurance*.	Subject to *deductible* and *coinsurance*.
Second Surgical Opinion	Subject to a $10 *copayment* per visit, then payable at 100%.	Subject to *deductible* and *coinsurance*.
Assisting the Surgeon	20% of the primary surgeon's fee, subject to *deductible* and *coinsurance*.	20% of the primary surgeon's fee, subject to *deductible* and *coinsurance*.
Physician Assistant	20% of the primary surgeon's fee, subject to *deductible* and *coinsurance*.	20% of the primary surgeon's fee, subject to *deductible* and *coinsurance*.
Routine Child Care (Ages 0-18)		
Exam and Immunizations	Subject to a $10 *copayment* per visit, then payable at 100%.	Subject to *deductible* and *coinsurance*.
Lab and X-ray (same site/same day as office visit)	Payable at 100%.	Subject to *deductible* and *coinsurance*.

*Non-PAR Providers are subject to *balance billing.*

Schedule of Benefits Continued

MEDICAL COVERED EXPENSES		
BENEFIT	**PAR PROVIDER (IN-NETWORK)**	**NON-PAR PROVIDER* (OUT-OF-NETWORK)**
Routine Adult Care (Ages 18 and over) Exam, Prostate Antigen Testing, Routine Pap Smear, Immunizations Routine Mammogram, Cardiovascular Screening Blood Test, Colorectal Cancer Screening Test, Bone Mass Measurements and Glaucoma Screening	Subject to a $10 *copayment* per visit, then payable at 100%.	Subject to *deductible* and *coinsurance*.
Lab and X-ray (same site/same day as office visit)	Payable at 100%.	Subject to *deductible* and *coinsurance*.
Ambulance Service	Subject to *deductible* and *coinsurance*.	Subject to PAR *deductible* and PAR *coinsurance*.
Pregnancy Benefits	Payable the same as any other *sickness*.	Payable the same as any other *sickness*.
	Office visit *copayment* is limited to the office visit in which pregnancy is diagnosed. Thereafter, no *copayment* required.	
Inpatient Newborn Benefits Well Newborn	Subject to *coinsurance*.	Subject to *coinsurance*.
Sick Newborn	Subject to *deductible* and *coinsurance*.	Subject to *deductible* and *coinsurance*.
Skilled Nursing Facility	Subject to *deductible* and *coinsurance*.	Subject to *deductible* and *coinsurance*.
	PAR and Non-PAR *covered expenses* aggregate to a maximum of 30 days per *calendar year*	
Home Health Care	Subject to *deductible* and *coinsurance*.	Subject to *deductible* and *coinsurance*.
	PAR and Non-PAR *covered expenses* aggregate to a maximum of 60 visits per *calendar year*.	
Hospice Care	Same as *Medicare* benefit.	Same as *Medicare* benefit.

*Non-PAR Providers are subject to *balance billing.*

Schedule of Benefits Continued

MEDICAL COVERED EXPENSES		
BENEFIT	**PAR PROVIDER (IN-NETWORK)**	**NON-PAR PROVIDER* (OUT-OF-NETWORK)**
Chiropractic Care		
Exam, Therapy, Manipulations and Routine *Maintenance Care**	Subject to a $10 *copayment* per visit, then payable at 100%.	Subject to *deductible* and *coinsurance*.
Lab and X-ray (same site/same day as office visit)	Payable at 100%.	Subject to *deductible* and *coinsurance*.
	*PAR and Non-PAR *covered expenses* aggregate to a maximum of 26 visits per *calendar year*, with no more than 1 visit per day.	
Physical Therapy	Subject to *deductible* and *coinsurance*.	Subject to *deductible* and *coinsurance*.
	PAR and Non-PAR *covered expenses* aggregate to a maximum of 30 visits per *calendar year*.	
Occupational Therapy	Subject to *deductible* and *coinsurance*.	Subject to *deductible* and *coinsurance*.
	PAR and Non-PAR *covered expenses* aggregate to a maximum of 30 visits per *calendar year*.	
Speech Therapy	Subject to *deductible* and *coinsurance*.	Subject to *deductible* and *coinsurance*.
	PAR and Non-PAR *covered expenses* aggregate to a maximum of 30 visits per *calendar year*.	
Cardiac Rehabilitation Therapy (Phase I and II)	Subject to *deductible* and *coinsurance*.	Subject to *deductible* and *coinsurance*.
	PAR and Non-PAR *covered expenses* aggregate to a maximum of 30 visits per *calendar year*.	
Respiratory Therapy	Subject to *deductible* and *coinsurance*.	Subject to *deductible* and *coinsurance*.
Chemotherapy and Radiation Therapy		
Office or Clinic Setting	Subject to a $10 *copayment* per visit, then payable at 100%.	Subject to *deductible* and *coinsurance*.
Outpatient Hospital Setting	Subject to *deductible* and *coinsurance*.	Subject to *deductible* and *coinsurance*.
Rehabilitation Centers	Subject to *deductible* and *coinsurance*.	Subject to *deductible* and *coinsurance*.
Allergy *Services*	Subject to a $10 *copayment* per visit, then payable at 100%.	Subject to *deductible* and *coinsurance*.

*Non-PAR Providers are subject to *balance billing.*

Schedule of Benefits Continued

MEDICAL COVERED EXPENSES		
BENEFIT	**PAR PROVIDER (IN-NETWORK)**	**NON-PAR PROVIDER* (OUT-OF-NETWORK)**
Hearing Aids (*Covered persons* under 18 years of age)	Subject to *deductible* and *coinsurance*.	Subject to *deductible* and *coinsurance*.
	PAR and Non-PAR *covered expenses* aggregate to a maximum of 1 *hearing aid* per ear every 3 years, up to a *maximum benefit* of $1,400 per ear.	
Temporomandibular Joint Disorder	Payable the same as any other *sickness*.	Payable the same as any other *sickness*.
Audiometric (in conjunction with a disease, *sickness* or *injury*	Payable the same as any other *sickness*.	Payable the same as any other *sickness*.
Family Planning		
Birth Control Devices	Subject to a $10 *copayment,* then payable at 100%.	Subject to *deductible* and *coinsurance*.
Contractive Injections	Subject to a $10 *copayment,* then payable at 100%.	Subject to *deductible* and *coinsurance*.
Contraceptive Implant Systems	Subject to a $10 *copayment,* then payable at 100%.	Subject to *deductible* and *coinsurance*.
Mental Disorder, Chemical Dependence and Alcoholism	Payable the same as any other *sickness*.	Payable the same as any other *sickness*.
Dental Injury		
Office or Clinic Setting	Subject to a $10 *copayment* per visit, then payable at 100%.	Subject to *deductible* and *coinsurance*.
Inpatient or *Outpatient* Setting	Subject to *deductible* and *coinsurance*.	Subject to *deductible* and *coinsurance*.
Other Covered Expenses	Subject to *deductible* and *coinsurance*.	Subject to *deductible* and *coinsurance*.
Sterilization		
Office or Clinic Setting	Subject to a $10 *copayment* per visit, then payable at 100%.	Subject to *deductible* and *coinsurance*.
Inpatient or *Outpatient* Setting	Subject to *deductible* and *coinsurance*.	Subject to *deductible* and *coinsurance*.

*Non-PAR Providers are subject to *balance billing.*

UTILIZATION/CASE MANAGEMENT

Utilization management and *case management* are designed to assist *covered persons* in making informed medical care decisions resulting in the delivery of appropriate levels of *Plan* benefits for each proposed course of treatment. These decisions are based on the medical information provided by the patient and the patient's *physician*. The patient and his or her *physician* determine the course of treatment. The assistance provided through these *services* does not constitute the practice of medicine. Payment of *Plan* benefits is not determined through these processes.

The *Plan Manager* does not reward doctors and other individuals for denying coverage or withholding *services.* Financial incentives are never offered. In fact, utilization management actually helps the *Plan Manager* make sure *you* get the preventive care and *medically necessary services you* need. *You* may request a review of the *medical necessity* and appropriateness of *hospital* resources and medical *services* given or proposed to be given to *you* for purposes of determining the availability of payment, referred to as a utilization review.

Additionally, *you* may request an internal appeal of the coverage decision within sixty (60) days of receiving notice of the decision if the decision involves a denial, reduction or termination of a benefit or the denial of payment for a *service*. Just call Customer Service at the number on *your* identification card to find out how.

Finally, *you* may also request an external review to be conducted by a certified independent review entity at the cost of the *Plan* if *you* have completed the internal appeal process and meet other conditions.

PRECERTIFICATION

Utilization review includes *precertification* and *concurrent review*.

This provision will not provide benefits to cover a *confinement* or *service* which is not *medically necessary* or otherwise would not be covered under the *Plan*. *Precertification* is not a guarantee of coverage.

If *you* or *your* covered *dependent* are to receive a *service* which requires *precertification*, *your qualified practitioner* must contact the *Plan Manager* by telephone or in writing. Refer to the Schedule of Benefits for time requirements.

After *your qualified practitioner* has provided the *Plan Manager* with *your* diagnosis and treatment plan, the *Plan Manager* will:

1. Advise *you* in writing if the proposed treatment plan is *medically necessary*;

2. Advise *you* in writing the number of days the *confinement* is initially *precertified*; and

3. Conduct *concurrent review* as necessary.

If *your qualified practitioner* extends *your confinement* beyond the number of days initially *precertified*, the extension must be *precertified* through *concurrent review*.

If it is determined at any time *your* proposed treatment plan, either partially or totally, is not a *covered expense* under the terms and provisions of the *Plan*, benefits for *services* may be reduced or *services* may not be covered.

PENALTY FOR NOT OBTAINING PRECERTIFICATION

If *your qualified practitioner* does not obtain *precertification* for *services* being rendered, *your* benefits for *hospital* or *qualified treatment facility* may be reduced. Refer to the Schedule of Benefits for the applicable penalty.

SECOND SURGICAL OPINION

When a *covered person* obtains a second opinion evaluation, such evaluation must be obtained within the procedures specified in the *Plan* delivery system rules described in the *covered person's certificate* in order for coverage to apply.

DISEASE MANAGEMENT

The *Disease Management Programs* require a coordinated and multi-dimensional approach to care. The goal is to help a *covered person* by providing education and information so they work better with their *qualified practitioner* to manage their conditions, avoid complications and maximize quality of life.

The *Disease Management Programs* listed in this section are available to *you* and any eligible *dependents* covered by this *Plan*. These *Disease Management Programs* are provided at no cost to *you*.

- **Congestive Heart Failure**: This program combines intervention, monitoring and education, which will enable *you* to take a more active role in managing *your* health.
- **Coronary Artery Disease**: This program's objective is to promote good health through education, counseling and support. This program offers educational materials on diet, medication management, exercise and, if appropriate, smoking cessation.
- **End Stage Renal Disease**: This program is designed to educate *you* and coordinate the multiple facets of *your* care.
- **Neonatal Intensive Care**: This program combines care coordination and parent education to help improve the patient's outcome and reduce stress on the family.
- **Cancer**: This program provides education, support and assistance regarding diagnosis and treatment of the patient's disease.
- **Chronic Kidney Disease**: This program combines care coordination and education as the patient is guided through a 5-step process during the course of their treatment.
- **Asthma**: This program was developed to provide education and environmental assessment of the patient's disease. This program also provides collaboration with the patient's *physician* to develop an appropriate treatment plan for controlling asthma.
- **Diabetes:** This program is designed to educate *you* and coordinate the multiple facets of *your* care.
- **Rare Diseases (Amyotrophic Lateral Sclerosis, or Lou Gehrig's Disease; Chronic Inflammatory Demyelinating Disease (CIDP); Cystic Fibrosis; Dermatomyositis; Hemophilia; Multiple Sclerosis; Myasthenia Gravis; Parkinson's Disease; Polymyositis; Rheumatoid Arthritis; Scleroderma; Sickle Cell Disease; and Systemic Lupus)**: *You* will be educated on the specifics of *your* disease, the possible complications and the treatment options available.

Utilization/Case Management Continued

- **Cerebrovascular/Stroke; Hypertension; Peripheral Artery Disease; Chronic Obstructive Pulmonary Disease (COPD); Osteoporosis Primary and Secondary; Gastroesophageal Reflux Disease (GERD); Peptic Ulcer Disease; Inflammatory Bowel Disease (IBD)/Crohn's; Chronic Hepatitis; Geriatrics; Seizure Disorders; Migraine; Hypercoagulable State; Oncology; HIV Support; Low Back Pain**: These programs are designed to educate *you* and coordinate the multiple facets of *your* care.

ACTIVE HEALTH MANAGEMENT

The *Plan Manager* has contracted with Active Health Management, Inc. to provide the CareEngine℠ Service in connection with *Plan* provisions aimed at monitoring quality, containing costs, and promoting efficient delivery of *covered services*.

The CareEngine℠ Service, uses a computer-assisted program which analyzes available medical and *hospital claims*, pharmacy and laboratory data according to evidence-based clinical rules and identifies *members* who may benefit from specific clinical interventions called Care Considerations which result in care improvement suggestions.

Care Considerations are communicated to the *member* through *Physician* messaging and *member* messaging. *Physician* messaging will be used by Active Health Management, Inc. to communicate the Care Consideration to the treating *physician* via phone, fax, or letter to suggest a change in the patient's treatment. *Member* messaging will be used to communicate to the *member* in the form of a letter using 'patient friendly' language emphasizing the same Care Consideration suggestions approximately two weeks after the initial letter reaches the treating *physician*.

PREDETERMINATION OF MEDICAL BENEFITS

You or *your qualified practitioner* may submit a written request for a *predetermination of benefits*. The written request should contain the treatment plan, specific diagnostic and procedure codes, as well as the expected charges. The *Plan Manager* will provide a written response advising if the *services* are a *covered* or non-*covered expense* under the *Plan*, what the applicable *Plan* benefits are and if the expected charges are within the *maximum allowable fee*. The *predetermination of benefits* is not a guarantee of benefits. *Services* will be subject to all terms and provisions of the *Plan* applicable at the time treatment is provided.

If treatment is to commence more than 90 days after the date treatment is authorized, the *Plan Manager* will require *you* to submit another treatment plan.

MEDICAL DEDUCTIBLE AND COINSURANCE INFORMATION

Covered expenses are payable, after satisfaction of the *deductible*, to a *maximum allowable fee* at the *coinsurance* percentages and up to the *maximum benefits* shown on the Schedule of Benefits.

DEDUCTIBLE

The *deductible* applies to each *covered person* each *calendar year* up to the family maximum. Only charges which qualify as a *covered expense* may be used to satisfy the *deductible*. The amount of the *deductible* is stated on the Schedule of Benefits.

If *you* and *your* covered *dependents* use a combination of *PAR* and *Non-PAR providers*, the PAR and Non-PAR *deductible* amounts will reduce each other.

MAXIMUM FAMILY DEDUCTIBLE

The total *deductible* applied to all *covered persons* in one family in a *calendar year* is subject to the maximum shown on the Schedule of Benefits.

COINSURANCE

The term *coinsurance* means the shared financial responsibility for *covered expenses* between the *covered person* and the self-insured plan.

Covered expenses are payable at the applicable percentage rate shown on the Schedule of Benefits after the *deductible* is satisfied each *calendar year*.

If *you* or *your* covered *dependents* use a *Non-PAR provider*, the *Plan Manager's* reimbursement will be payable on a *maximum allowable fee* basis. Any amounts above the *maximum allowable fee* will be the *member's* responsibility and will NOT apply to the *out-of-pocket limit*.

OUT-OF-POCKET LIMIT

When the amount of combined *covered expenses* paid by *you* and/or all *your* covered *dependents* satisfy the *out-of-pocket limits*, including the *deductible* as shown on the Schedule of Benefits, the *Plan* will pay 100% of *covered expenses* for the remainder of the *calendar year*, unless specifically indicated, subject to any *calendar year* maximums of the *Plan*.

If *you* and *your* covered *dependents* use a combination of *PAR* and *Non-PAR providers*, the combined out-of-pocket will not exceed the *Non-PAR provider out-of-pocket limit*. Office visit *copayments*, *hospital emergency room copayments*, *urgent care copayments* and charges above the allowable fee for non-PAR providers are not applied to the *out-of-pocket limit*.

If *you* and *your* covered *dependents* use a combination of *PAR* and *Non-PAR providers*, the PAR and Non-PAR out-of-pocket amounts will reduce each other.

Covered expenses are subject to any *calendar year* maximums of the *Plan*.

LIFETIME MAXIMUM

Lifetime maximum means the maximum amount of benefits available while *you* are covered under the *Plan*. Under no circumstances does lifetime mean during the lifetime of the *covered person*. This *Plan* does not include a lifetime maximum.

MEDICAL COVERED EXPENSES

INPATIENT HOSPITAL

Covered expenses are payable as shown on the Schedule of Benefits and include charges made by:

1. Benefits for room and board when the *covered person* occupies:
   a. A room with two (2) or more beds, known as a semi-private room or ward; or
   b. A private room. The private room allowances shall be limited to an amount equal to the *hospital's* average semi-private rate. In cases of a facility which only has private rooms, then the average semi-private rate does not apply; or
   c. A private room for the distinct purpose of medical isolation. Coverage is limited to the period of time for which medical isolation is *medically necessary*. Such cases require specific pre-certification approval by the *Plan*; or
   d. A bed in a special care unit, including nursing *services* - a designated unit which is approved by the *Plan* and has concentrated facilities, equipment, and supportive *services* for the provision of an intensive level of care for critically ill patients.

2. *Hospital* Ancillary *services* and supplies including, but not restricted to:
   a. Use of operating, delivery, and treatment rooms and equipment;
   b. Prescription drugs administered to an *inpatient*;
   c. Administration of blood and blood processing, blood clotting elements, factors eight (8) and nine (9) for blood clotting enhancements in relation to hemophilia, and gamma globulin used in the treatment of hepatitis;
   d. Anesthesia, anesthesia supplies and *services* rendered by an *employee* of the *hospital* or through approved contractual arrangements;
   e. Medical and surgical dressings, supplies, casts, and splints;
   f. Diagnostic *services*;
   g. *Therapy services*; and
   h. Special care unit nursing *services*, other than the portion payable under (1)(d) above.

OUTPATIENT HOSPITAL

Outpatient hospital/ambulatory surgical center facility/other provider *services*

1. *Surgery*, which includes facility *services* and supplies, anesthesia, anesthesia supplies, and *services* rendered by an employee of the facility other than the surgeon or assistant surgeon.
2. Ancillary *services* listed below and furnished to an *outpatient*, if pre-authorized by the *Plan*:
   a. Use of operating room and recovery rooms;
   b. Respiratory therapy e.g., oxygen;
   c. Administered drugs and medicine;
   d. Intravenous solutions;
   e. Dressings, including ordinary casts, splints, or trusses;
   f. Anesthetics and their administration;
   g. Transfusion supplies and equipment;
   h. Diagnostic *services*, including radiology, ultrasound, laboratory, pathology, and approved machine testing e.g., electrocardiogram (EKG);
   i. Chemotherapy treatment for proven malignant disease;
   j. Radiation therapy; treatment by x-ray, radium or radioactive isotopes; and
   k. Renal dialysis treatment for acute or chronic kidney ailment which may include the supportive use of an artificial kidney machine.

EMERGENCY CARE

Benefits are provided for treatment of *emergency* medical conditions and *emergency* screening and stabilization *services* without prior authorization for conditions that reasonably appear to a prudent lay person to constitute an *emergency* medical condition based upon the patient's presenting symptoms and conditions. Benefits for *emergency* care include facility costs, physician *services*, supplies and prescriptions.

Care in *hospital emergency* rooms is subject to the *emergency* room *copayment* and/or *coinsurance* as indicated on the Schedule of Benefits. The *emergency* room *copayment* shall not be required if the *covered person* is admitted, within twenty-four (24) hours, as an *inpatient* for the condition for which he/she sought *emergency* care.

If a *covered person* is admitted to a *hospital* for *emergency* care outside the *service area*, the *Plan*, after consultation with the attending physician, may require that the *covered person* be transferred to a participating *hospital* as soon as medically feasible.

Benefits are not provided for the use of an *emergency* room except for treatment of *emergency* medical conditions, *emergency* screening and stabilization. All follow-up or continued care, *services* or prescriptions, must be authorized by the *Plan*, if such approval is required by *your Plan*.

FREE-STANDING SURGICAL FACILITY

Charges made by a *free-standing surgical facility*, for surgical procedures performed and for *services* rendered in the facility are payable as shown on the Schedule of Benefits.

URGENT CARE

Benefits are provided for *urgent care* at a freestanding or hospital-based *urgent care* facility when the *covered person* is outside the *service area* or when the primary care *physician* is unavailable and when care:

1. is required to prevent serious deterioration in the *covered person's* health;
2. could not have been foreseen prior to leaving the *service area* or during normal office hours;
3. is not an *emergency* medical condition, but requires prompt medical attention;
4. includes, but is not limited to, the treatment of significant injuries as a result of accidents, the relief or elimination of severe pain, or the moderation of an acute illness; and
5. is obtained in accordance with the benefit booklet *plan delivery system rules*.

MEDICAL CARE TO INPATIENTS

Benefits for medical care to *inpatients* are limited to:

1. Visits by the attending *physician*;
2. Intensive medical care (Medical care requiring a *physician's* constant attendance);
3. Concurrent medical care
    a. Medical care in addition to *surgery* during the same admission for unrelated medical conditions. This medical care is provided by a *physician* other than the operating surgeon.
    b. Medical care by two (2) or more *physicians* during the same admission for unrelated medical conditions. The medical care must require the skills of separate *physicians*; and
4. Consultations provided by a *physician* at the request of the attending *physician*. Consultations do not include staff consultations required by *hospital* rules and regulations.

QUALIFIED PRACTITIONER

Covered expenses are payable as shown on the Schedule of Benefits and include charges made by a *qualified practitioner* when incurred for:

1. Office, home, *emergency* room *physician* or *inpatient hospital* visits;

2. Diagnostic Testing which includes: laboratory tests, x-rays and other radiology or imaging *services*; and ultrasound and approved machine testing *services* performed for the purpose of diagnosing a *sickness* or injury.

3. Professional *services* of a radiologist or pathologist for diagnostic x-ray examination or laboratory tests, including x-ray, radon, radium and radioactive isotope therapy;

4. Other covered medical *services* received from or at the direction of a *qualified practitioner*;

5. Administration of anesthesia. Coverage is provided for the *services* of a *physician* or other professional *provider* (other than the surgeon or assistant surgeon) for administration of anesthesia, as ordered by the attending *physician*;

6. A surgical procedure, including pre-operative and post-operative care.

    If multiple or bilateral surgical procedures are performed at one operative session, the amount payable for these procedures will be limited to the *maximum allowable fee* for the primary surgical procedure and;

    a. 50% of the *maximum allowable fee* for the secondary procedure; and

    b. 25% of the *maximum allowable fee* for the third and subsequent procedures.

    No benefits will be payable for incidental procedures.

Qualified Practitioner Continued

7. Assisting the surgeon;

8. *Physician* assistant;

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

    a. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological examination;

    b. Surgical procedures required to correct *accidental injuries* of the jaws, cheeks, lips, tongue, roof and floor of the mouth;

    c. Reduction of fractures and dislocations of the jaw; and

    d. Incision of accessory sinuses, salivary glands or ducts;

ROUTINE CARE

The following expenses are payable for *you* or *your* covered *dependent*, up to the amount shown on the Schedule of Benefits, subject to all terms and provisions of the *Plan*, except the exclusion for *services* which are not *medically necessary*, if *you* are not confined in a *hospital* or *qualified treatment facility* and if such expenses are not incurred for diagnosis of a specific *bodily injury* or *sickness.*

Benefits include:

1. Routine exams and annual checkups;

2. Immunizations;

3. Pap smears, one per *calendar year*;

4. Mammograms in accordance with age guidelines listed below:
    a. A baseline mammogram one time for women between the ages 35 through 39;
    b. One mammogram annually for women age 40 and over; and
    c. One mammogram per year for women at risk.

    Women at risk are described as follows:
    a. One with a personal history of breast cancer;
    b. One with a personal history of breast disease which was benign upon biopsy;
    c. One whose mother, sister or daughter had breast cancer; or
    d. One who is 30 or over and has never given birth.

5. Routine x-ray and laboratory tests;

6. Prostate antigen testing;

Routine Care Continued

7. Cardiovascular Screening Blood Test;

8. Colorectal Cancer Screening Test;

9. Bone Mass Measurements;

10. Glaucoma Screening.

No benefits are payable under this benefit for:

1. Any dental examinations;

2. Hearing examinations;

3. Medical examination for *bodily injury* or *sickness*;

4. Medical examination caused by or resulting from pregnancy.

AMBULANCE SERVICE

1. *Ambulance* service providing local transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured:
    a. from a *covered person's* home or scene of *accident* or medical *emergency* to the closest facility that can provide *covered services* appropriate to the *covered person's* condition. If there is no facility in the local area that can provide *covered services* appropriate to the covered person's condition, ambulance service means transportation to the closest facility outside the local area that can provide the necessary *services*;
    b. between *hospitals*; and
    c. between a *hospital* and nursing facility, with prior approval of the *Plan*.
2. When approved by the *Plan*, *ambulance* service providing local transportation by means of a specially designed vehicle used only for transporting the sick and injured:
    a. from a hospital to the *covered person's* home; or
    b. from a nursing facility to the *covered person's* home when the transportation to the facility would qualify as a *covered service*.

Benefits are limited to *services* involving admissions for *inpatients* or treatment of an *outpatient* for *emergency* care.

PREGNANCY BENEFITS

Pregnancy is a *covered expense* for any *covered person* payable as shown on the Schedule of Benefits.

Complications of pregnancy are payable as any other covered *sickness* at the point the complication sets in for any *covered person*.

Pregnancy benefits are subject to all terms and provisions of the *Plan*, with the exception of the *pre-existing condition* limitation.

Pregnancy Benefits Continued

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending *provider*, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans may not, under Federal law, require that a *provider* obtain authorization from the *Plan* or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

NEWBORN BENEFITS

Benefits for newborns are subject to the Eligibility and Effective Date of Coverage section of this booklet, as well as all terms and provisions of the *Plan*, with the exception of the *pre-existing condition* limitation as defined within the Definitions section of this booklet.

WELL-NEWBORN

Covered expenses incurred during a well-newborn child's initial *inpatient hospital confinement* include *hospital* expenses for nursery room and board and miscellaneous *services*; *qualified practitioner's* expenses for circumcision; and *qualified practitioner's* expenses for routine examination before release from the *hospital*.

SICK-NEWBORN

Covered expenses for a sick-newborn are *expenses incurred* for the treatment of a *bodily injury* or *sickness*.

SKILLED NURSING FACILITY

Covered expenses for a skilled nursing facility *confinement* are payable when the *confinement*:

1. Begins while *you* or an eligible *dependent* are covered under this *Plan*;

2. Begins after discharge from a *hospital confinement* or a prior covered skilled nursing facility *confinement*;

3. Is necessary for care or treatment of the same *bodily injury* or *sickness* which caused the prior *confinement*; and

4. Occurs while *you* or an eligible *dependent* are under the regular care of the *physician* who *precertified* the required skilled nursing facility *confinement*.

Skilled nursing facility means only an institution licensed as a skilled nursing facility and lawfully operated in the jurisdiction where located. It must maintain and provide:

1. Permanent and full-time bed care facilities for resident patients;

2. A *physician's services* available at all times;

Skilled Nursing Facility Continued

3. 24-hour-a-day skilled nursing *services* under the full-time supervision of a *physician* or registered nurse (R.N.);

4. A daily record for each patient;

5. Continuous *skilled nursing care* for sick or injured persons during their convalescence from *sickness* or *bodily injury*; and

6. A *utilization review* plan.

A skilled nursing facility is not except by incident, a rest home, a home for care of the aged, or engaged in the care and treatment of *mental disorders*, chemical dependence or alcoholism.

BENEFITS PAYABLE

Expense incurred for daily room and board and general nursing *services* for each day of *confinement* in a skilled nursing facility is payable as shown on the Schedule of Benefits. The daily rate will not exceed the maximum daily rate established for licensed *skilled nursing care* facilities by the Department of Health and Social Services.

HOME HEALTH CARE

Expense incurred for home health care as described below is payable as shown on the Schedule of Benefits.

Each visit by a home health care *provider* for evaluating the need for, developing a plan, or providing *services* under a home health care plan will be considered one home health care visit. Up to 4 consecutive hours of service in a 24-hour period is considered one home health care visit. A visit by a home health care *provider* of 4 hours or more is considered one visit for every 4 hours or part thereof.

Home health care *provider* means an agency licensed by the proper authority as a *home health agency* or *Medicare* approved as a *home health agency*.

Home health care will not be reimbursed unless the *Plan* determines:

1. Hospitalization or *confinement* in a skilled nursing facility would otherwise be required if home care were not provided;

2. Necessary care and treatment are not available from a *family member* or other persons residing with *you*; and

3. The home health care *services* will be provided or coordinated by a state-licensed or *Medicare*-certified *home health agency* or certified rehabilitation agency.

The home health care plan must be reviewed and approved by the *qualified practitioner* under whose care *you* are currently receiving treatment for the *bodily injury* or *sickness* which requires the home health care.

Home Health Care Continued

The home health care plan consists of:

1. Care by or under the supervision of a registered nurse (R.N.);

2. Physical, speech, occupational and respiratory therapy and home health aide *services*; and

3. Medical supplies and *durable medical equipment*, laboratory *services* and nutritional counseling, if such *services* and supplies would have been covered if *you* were *hospital* confined.

LIMITATIONS ON HOME HEALTH CARE BENEFITS

Home health care benefits do not include:

1. Charges for mileage or travel time to and from the *covered person's* home;

2. Wage or shift differentials for home health care *providers*; or

3. Charges for supervision of home health care *providers*.

HOSPICE CARE

Hospice services must be furnished in a *hospice* facility or in *your* home. A *qualified practitioner* must certify *you* are terminally ill with a life expectancy of six months or less.

For *hospice services* only, *your* immediate family is considered to be *your* parent, *spouse*, and *your* children or step-children.

Covered expenses are payable as shown on the Schedule of Benefits for the following *hospice services*:

1. Room and board and other *services* and supplies;

2. Part-time nursing care by or supervised by a R.N. for up to 8 hours per day;

3. Counseling *services* by a *qualified practitioner* for the *hospice* patient and the immediate family;

4. Medical social *services* provided to *you* or *your* immediate family under the direction of a *qualified practitioner*, which include the following:

    a. Assessment of social, emotional and medical needs, and the home and family situation,

    b. Identification of the community resources available, and

    c. Assistance in obtaining those resources;

5. Nutritional counseling;

6. Physical or occupational therapy;

Hospice Care Continued

7. Part-time home health aide service for up to 8 hours in any one day;

8. Medical supplies, drugs and medicines prescribed by a *qualified practitioner*; and

9. Bereavement counseling *services* by a *qualified practitioner* for *your* immediate family.

LIMITATIONS ON HOSPICE CARE BENEFITS

Hospice care benefits do NOT include: (1) private duty nursing *services* when confined in a *hospice* facility; (2) a *confinement* not required for pain control or other acute chronic symptom management; (3) funeral arrangements; (4) financial or legal counseling, including estate planning or drafting of a will; (5) homemaker or caretaker *services*, including a sitter or companion *services*; (6) housecleaning and household maintenance; (7) *services* of a social worker other than a licensed clinical social worker; (8) *services* by volunteers or persons who do not regularly charge for their *services*; or (9) *services* by a licensed pastoral counselor to a *member* of his or her congregation when *services* are in the course of the duties to which he or she is called as a pastor or minister.

Hospice care program means a written plan of *hospice* care, established and reviewed by the *qualified practitioner* attending the patient and the *hospice* care agency, for providing palliative and supportive care to *hospice* patients. It offers supportive care to the families of *hospice* patients, an assessment of the *hospice* patient's medical and social needs, and a description of the care to meet those needs.

Hospice facility means a licensed facility or part of a facility which principally provides *hospice* care, keeps medical records of each patient, has an ongoing quality assurance program and has a *physician* on call at all times.

A *hospice* facility provides 24-hour-a-day nursing *services* under the direction of a R.N. and has a full-time administrator.

Hospice care agency means an agency which has the primary purpose of providing *hospice services* to *hospice* patients. It must be licensed and operated according to the laws of the state in which it is located and meets all of these requirements: (1) has obtained any required certificate of need; (2) provides 24-hours a day, 7 day-a-week service supervised by a *qualified practitioner*; (3) has a full-time coordinator; (4) keeps written records of *services* provided to each patient; (5) has a nurse coordinator who is a R.N., who has four years of full-time clinical experience, of which at least two involved caring for terminally ill patients; and, (6) has a licensed social service coordinator.

A *hospice* care agency will establish policies for the provision of *hospice* care, assess the patient's medical and social needs and develop a program to meet those needs. It will provide an ongoing quality assurance program, permit area medical personnel to use its *services* for their patients, and use volunteers trained in care of and *services* for non-medical needs.

CHIROPRACTIC CARE

Covered expenses for chiropractic care are payable as shown on the Schedule of Benefits.

HEARING AIDS AND RELATED SERVICES

Coverage shall be provided, subject to all applicable *copayment*, coinsurance, deductibles and out-of-pocket limits, for the full cost of one (1) *hearing aid* per hearing impaired ear up to $1,400 every 36 months for *hearing aids* for a *covered person* under 18 years of age and all related services which shall be prescribed by an audiologist and dispensed by an audiologist or hearing instrument specialist. The *covered person* may choose a higher priced *hearing aid* and may pay the difference in cost above the $1,400 limit as provided.

Coverage shall not be required for a *hearing aid* claim if any health benefit plan has paid a claim for a *hearing aid* within the 3 years prior to the date of the claim.

TEMPOROMANDIBULAR JOINT DISORDER

Covered services incurred for surgical treatment of temporomandibular joint (TMJ), craniomandibular joint (CMJ), or craniomandibular jaw (orthognathic) disorder (provided the charges are for *services* included in a treatment plan authorized under the plan prior to the surgery). TMJ or CMJ disorder is a jaw/joint disorder which may cause pain, swelling, clicking and difficulties in opening and closing the mouth and complications include arthritis, dislocation and bite problems of the jaw. Craniomandibular jaw (orthognathic) disorders involve documented skeletal disorders of the jaw. Procedures for the treatment of craniomandibular jaw maldevelopments that are not correctable with conventional orthodontic treatment yielding a stable and functional post-treatment occlusion without worsening the patient's esthetic condition shall be covered surgical procedures.

Covered services for non-surgical diagnosis and treatment of TMJ or CMJ dysfunction or disorder or craniomandibular jaw disorders are limited to:

1. diagnostic examination;
2. diagnostic x-rays;
3. injection of muscle relaxants;
4. therapeutic drug injections;
5. physical therapy;
6. diathermy therapy;
7. ultrasound therapy;
8. splint therapy; and
9. arthrocentesis and aspiration.

Benefits are not provided for anything not listed above, including but not limited to:

1. any appliance or the adjustment of any appliance involving orthodontics;
2. any electronic diagnostic modalities;
3. occlusal analysis; and
4. muscle testing.

MENTAL DISORDER, CHEMICAL DEPENDENCE OR ALCOHOLISM BENEFIT

Expense incurred by *you* during a plan of treatment for *mental disorder*, chemical dependence or alcoholism is payable for:

1. Charges made by a *qualified practitioner*;

2. Charges made by a *hospital*;

3. Charges made by a *qualified treatment facility*;

4. Charges for x-ray and laboratory expenses.

INPATIENT BENEFITS

Covered expenses while confined as a registered bed patient in a *hospital* or *qualified treatment facility* are payable as shown below:

PAR PROVIDER (IN-NETWORK)	NON-PAR PROVIDER (OUT-OF-NETWORK)
Subject to *deductible* and payable at 80%.	Subject to *deductible* and payable at 60%.

Covered expenses for *inpatient* treatment aggregate toward the *coinsurance* and *out-of-pocket limits* described on the Schedule of Benefits.

OUTPATIENT BENEFITS

Covered expenses for *outpatient* treatment received while not confined in a *hospital* or *qualified treatment facility* are payable as shown below:

PAR PROVIDER (IN-NETWORK)	NON-PAR PROVIDER (OUT-OF-NETWORK)
Subject to a $10 *copayment*, then payable at 100%.	Subject to *deductible* and payable at 60%.

Covered expenses for *outpatient* treatment aggregate toward the *coinsurance* and *out-of-pocket limits* described on the Schedule of Benefits.

TRANSITIONAL TREATMENT

Covered expenses received for transitional treatment arrangements are payable as shown below:

PAR PROVIDER (IN-NETWORK)	NON-PAR PROVIDER (OUT-OF-NETWORK)
Subject to *deductible* and payable at 80%.	Subject to *deductible* and payable at 60%.

Covered expenses for transitional treatment aggregate toward the *coinsurance* and *out-of-pocket limits* described on the Schedule of Benefits.

Transitional treatment arrangements mean *covered expenses* for the treatment of *mental disorders*, chemical dependence or alcoholism that are provided to *you* in a less restrictive manner than are *inpatient hospital services*, but in a more intensive manner than are *outpatient services* (includes but is not limited to day hospitalization).

AUTISM BENEFITS

Covered expenses for *autism* benefits are payable as shown below, subject to the lifetime maximum of the Plan.

Covered expenses for *autism* benefits aggregate toward the *out-of-pocket limits* described on the Schedule of Benefits.

Autism benefits are for rehabilitative, therapeutic and respite *services*. There is a $500 monthly benefit for children ages 2 through 21 years of age. This benefit shall not apply to other health or *mental health conditions* which are not related to the treatment of *autism*. *Services* are subject to the same *copayments* as though the *services* were provided for any other *sickness*.

AUTISM BENEFIT	PAR PROVIDER (IN-NETWORK)	NON-PAR PROVIDER (OUT-OF-NETWORK)
Rehabilitative and Therapeutic Care *Services*	Subject to a $10 *copayment,* then payable at 100%.	Subject to *deductible* and payable at 60%.
Respite Care	Subject to *deductible* and payable at 50%.	Subject to PAR *deductible* and payable at 50%.

LIMITATIONS ON MENTAL DISORDER, CHEMICAL DEPENDENCE OR ALCOHOLISM BENEFITS

No benefits are payable under this provision for marriage counseling, treatment of nicotine habit or addiction, or for treatment of being obese or overweight.

No benefits are payable under this provision for *services* performed at a Residential Treatment Facility.

Treatment must be provided for the cause for which benefits are payable under this provision of the Plan.

Medications or other prescription drugs used by an outpatient to maintain an addiction or dependency on drugs, alcohol, or chemicals. *Services,* supplies, or other care associated with the treatment of substance abuse whenever the covered person fails to comply with the plan of treatment (such as detoxification, rehabilitation or care as an outpatient) for which the *services,* supplies, or other care was rendered or a claim was submitted.

KENTUCKY EMPLOYEE ASSISTANCE PROGRAM (KEAP) FOR STATE AGENCIES

Your employer offers a voluntary Kentucky Employee Assistance Program (KEAP) for treatment of *mental disorders,* chemical dependence or alcoholism for *you* or *your* covered *dependents.* For more information, contact the Employee Assistance Program at:

Kentucky Employee Assistance Program
408 Wapping Street
Frankfort, Kentucky 40601
(502) 564-5788
(800) 445-5327

OTHER COVERED EXPENSES

The following are other *covered expenses* payable as shown on the Schedule of Benefits:

1. Blood and blood plasma are payable as long as it is NOT replaced by donation, and administration of blood and blood products including blood extracts or derivatives;

2. Oxygen and rental of equipment for its administration;

3. Initial prosthetic devices or supplies, including but not limited to, limbs and eyes. Coverage will be provided for prosthetic devices necessary to restore minimal basic function. Replacement is a *covered expense* if due to pathological changes. *Covered expense* includes repair of the prosthetic device if not covered by the manufacturer;

4. Casts, trusses, crutches, splints except for dental splints, and braces except for orthodontic braces;

5. Supplies, up to a 30-day supply, when prescribed by *your* attending *physician*;

6. Initial contact lenses or eyeglasses following cataract *surgery*;

7. The rental, up to but not to exceed the purchase price, of a wheelchair, *hospital* bed, ventilator, *hospital* type equipment or other *durable medical equipment (DME)*. The Plan, at its option, may authorize the purchase of *DME* in lieu of its rental, if the rental price is projected to exceed the purchase price. Repair, maintenance or duplicate *DME* rental is not considered a *covered expense*;

8. Chiropractic care for treatment of a *bodily injury* or *sickness*. *Maintenance care* is not covered;

9. *Services* for the treatment of a *dental injury* to a *sound natural tooth*, including but not limited to extraction and initial replacement. The *dental injury* shall be of sufficient significance that initial contact for evaluation shall occur within 72 hours of the accident. *Services* must begin within 90 days and be completed within 12 months after the date of the *dental injury*. Benefits will be paid only for *expense incurred* for the least expensive *service* that will, in the *Plan Manager's* opinion, produce a professionally adequate result;

10. Benefit plans that provide coverage for general anesthesia and hospitalization *services* to a *covered person* shall provide coverage for payment of anesthesia and *hospital* or facility charges for *services* performed in a *hospital* or ambulatory surgical facility in connection with dental procedures for children below the age of 9 years, persons with serious mental or physical conditions, and persons with significant behavioral problems, where the admitting *physician* or treating dentist certifies that, because of the patient's age, condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures. The same *deductibles*, *coinsurance*, network requirements, *medical necessity* provisions, and other limitations as apply to physical *sickness* benefits shall apply to coverage for anesthesia and *hospital* or facility charges covered in this section.

    Coverage for routine dental care, including the diagnosis or treatment of disease or other dental conditions and procedures are not covered.

11. Installation and use of an insulin infusion pump, diabetic self-management education programs and other equipment in the treatment of diabetes;

Other Covered Expenses Continued

12. Reconstructive *surgery* due to *bodily injury*, infection or other disease of the involved part or congenital disease or anomaly of a covered *dependent* child which resulted in a functional defect;

13. Reconstructive *services* following a covered mastectomy, including but not limited to:

    a. reconstruction of the breast on which the mastectomy was performed;

    b. reconstruction of the other breast to achieve symmetry;

    c. prosthesis; and

    d. treatment of physical complications of all stages of the mastectomy, including lymphedemas;

14. Speech, occupational, and physical therapy;

15. Chemotherapy, radiation and respiratory therapy, as *medically necessary*;

16. Cardiac rehabilitation, limited to phases I and II;

17. Surgery for *morbid obesity*, when qualified as *morbid obesity*, *medically necessary* and the *covered persons* condition is of a life-threatening nature;

18. Audiometric *services* covered only in conjunction with a disease, *sickness* or injury;

19. Cochlear Implants;

20. *Telehealth* Consultation *services*. Covered *services* include a medical or health consultation for purposes of patient diagnosis or treatment that requires the use of advanced telecommunications technology, including, but not limited to: (a) compressed digital interactive video, audio, or data transmission; and (b) clinical data transmission via computer imaging for teleradiology or telephathology; and (c) other technology that facilitates access to other covered health care *services* or medical specialty expertise;

21. Bone Density Testing for women ages 35 and older;

22. Immunizations in accordance with recommendations of the Advisory Council on Immunization Practices of the Centers for Disease Control and Prevention and Therapeutic injections.

The following *services* are considered other *covered expenses* and are payable as shown on the Schedule of Benefits, subject to all terms and provisions of the Plan, except the exclusion for *services* which are not *medically necessary*:

1. Elective sterilizations, regardless of *medical necessity*, coverage is provided for *outpatient* procedures performed for the sole purpose of voluntary sterilization. No coverage is provided for the reversal or any attempted reversal of a previously performed sterilization;

2. Birth control devices, injections, or implant systems.

ORGAN TRANSPLANT BENEFIT

The Plan will pay benefits for the expense of a transplant as defined below when incurred by a *covered person* and approved in advance by the *Plan Manager*, subject to those terms, conditions and limitations described below and contained in the Plan. Please contact the *Plan Manager* when in need of these *services*.

COVERED ORGAN TRANSPLANT

Only the *services*, care, and treatment received for or in connection with the pre-approved transplant of the organs identified hereafter, which are determined by the *Plan Manager* to be *medically necessary services* and which are not *experimental, investigational or for research purposes*. The transplant includes pre-transplant, transplant inclusive of any chemotherapy and associated *services*, post-discharge *services*, and treatment of complications after transplantation of the following organs or procedures only:

1. Heart;
2. Lung(s);
3. Heart-lung;
4. Liver;
5. Kidney;
6. Bone Marrow;
7. Intestine;
8. Simultaneous pancreas/kidney;
9. Pancreas following kidney;
10. Any organ not listed above required by state or federal law.

The term bone marrow identified in the foregoing transplant definition refers to the transplant of human blood precursor cells which are administered to a patient following high-dose, ablative or myelosuppresive chemotherapy. Such cells may be derived from bone marrow, circulating blood, or a combination of bone marrow and circulating blood obtained from the patient in an autologous transplant or from a matched related or unrelated donor or cord blood. If chemotherapy is an integral part of the treatment involving a transplant of bone marrow, the term bone marrow includes the harvesting, the transplantation and the chemotherapy components. Storage of cord blood and stem cells will not be covered unless as an integral part of a transplant of bone marrow approved by the *Plan Manager*.

Organ Transplant Benefit Continued

Corneal transplants and porcine heart valve implants, which are tissues rather than organs, are considered part of regular plan benefits and are subject to other applicable provisions of the Plan.

For a transplant to be considered fully approved, prior written approval from the *Plan Manager* is required in advance of the transplant. Y*ou* or *your qualified practitioner* must notify the *Plan Manager* in advance of *your* need for an initial evaluation for the transplant in order for the *Plan Manager* to determine if the transplant will be covered. For approval of the transplant itself, the *Plan Manager* must be given a reasonable opportunity to review the clinical results of the evaluation before rendering a determination.

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

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

Benefits are provided for *medically necessary* adult-to-adult right lobe living donor liver transplant. Benefits are not provided for adult-to-adult left lobe living donor liver transplant.

Benefits are provided for heart transplants that are *medically necessary* and not *experimental or investigational*.

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

Disease

Acute lymphocytic leukemia	covered
Acute myelogenous leukemia	covered
Chronic myelogenous leukemia	covered
Chronic lymphocytic leukemia	not covered
Small cell lymphocytic leukemia	not covered
Epithelial Ovarian Cancer	not covered
Malignant Astrocytomas and Glioma	not covered
Primitive Neuroectodermal Tumors	covered
Ependymoma	not covered
Pediatric Neuroblastoma	covered
Recurrent Ewing's Sarcoma	covered
Germ Cell Tumors	covered
Any tandem procedures	not covered
Multiple Myeloma	covered
Hodgkin's Lymphoma	covered
Non-Hodgkin's Lymphoma	covered
Myelodysplastic Diseases	covered
Aplastic Anemia	covered
Wiskott-Aldrich syndrome	covered
Severe Combined Immunodeficiency Disorder	covered
Albert-Schoenberg Syndrome	covered
Homozygous beta-thalassemia	covered

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

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

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

Benefits are provided for lung transplants that are *medically necessary* and not *experimental or investigational*.

Benefits are provided for heart/lung transplants that are *medically necessary* and not *experimental or investigational*.

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

Organ Transplant Benefit Continued

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

The Plan may amend the above Covered Transplant Procedure list to include additional diagnoses when published peer-reviewed studies establish that transplantation has a positive long-term outcome.

ORGAN TRANSPLANT EXCLUSIONS

No benefit is payable for or in connection with a transplant if:

1. It is *experimental, investigational or for research purposes* as defined elsewhere in the Plan.

2. The *Plan Manager* is not contacted for authorization prior to referral for evaluation of the transplant, unless such authorization is waived by the *Plan Manager*.

3. The *Plan Manager* does not approve coverage for the transplant, based on its established criteria.

4. Expenses are eligible to be paid under any private or public research fund, government program except Medicaid, or another funding program, whether or not such funding was applied for or received.

5. The expense relates to the transplantation of any non-human organ or tissue, unless otherwise stated in the Plan.

6. The expense relates to the donation or acquisition of an organ for a recipient who is not covered by the Plan.

7. A denied transplant is performed; this includes the pre-transplant evaluation, the transplant procedure, follow up care, immunosuppressive drugs, and complications of such transplant.

8. The *covered person* for whom a transplant is requested has not met pre-transplant criteria as established by the *Plan Manager*.

Once the transplant is approved, the *Plan Manager* will advise the *covered person's qualified practitioner*. Benefits are payable only if the pre-transplant *services*, the transplant and post-discharge *services* are approved by the *Plan Manager*.

COVERED ORGAN TRANSPLANT SERVICES

For approved transplants, and all related complications, the *Plan Manager* will cover only the following expenses:

1. *Hospital* benefits shown in the Schedule of Benefits under the *Hospital* Benefit section of this Plan will be paid at: (a) 80% of *covered expenses,* subject to *deductible,* if received at a PAR *hospital* designated by the *Plan Manager* as an approved transplant facility; and (b) 60% of *covered expenses,* subject to *deductible,* if received at a Non-PAR *hospital*.

Organ Transplant Benefit Continued

Qualified practitioner benefits shown in the Schedule of Benefits under the Q*ualified Practitioner* section of this Plan will be paid at (a) 80% of *covered expenses*, subject to *deductible*, if received from a PAR *qualified practitioner* designated by the *Plan Manager* as an approved transplant *provider*; and (b) 60% of *covered expenses*, subject to *deductible*, if received from a Non-PAR *qualified practitioner*.

Any *coinsurance* directly related to the benefit in this section of the Plan does apply toward any *out-of-pocket limits* or *deductible(s)* shown elsewhere in the Plan.

2. Organ acquisition and donor costs. Except for bone marrow transplants, donor costs are not payable under the Plan if they are payable in whole or in part by any other group plan, insurance company, organization or person other than the donor's family or estate. Coverage for bone marrow transplants procedures will include costs associated with the donor-patient to the same extent and limitations associated with the *covered person*, except the reasonable costs of searching for the donor may be limited to the immediate *family member*s and the National Bone Marrow Donor Program.

3. Direct, non-medical costs for the *covered person* receiving the transplant will be paid for: (a) transportation to and from the *hospital* where the transplant is performed; and (b) temporary lodging at a prearranged location up to $75 per day when requested by the *hospital* and approved by the *Plan Manager*. Transportation costs for the *covered person* to and from the *hospital* where the transplant is performed will be paid at: (a) 80% of *covered expenses*, subject to *deductible*, if the transplant is received at a PAR *hospital* designated by the *Plan Manager* as an approved transplant facility; or, (b) 60% of *covered expenses*, subject to *deductible*, if the transplant is received at a Non-PAR *hospital*. These direct, non-medical costs are only available if the *covered person* lives more than 100 miles from the transplant facility.*

4. Direct, non-medical costs for one *member* of the *covered person's* immediate family or a companion (two *members* if the patient is under age 18 years) will be paid for: (a) transportation to and from the approved facility where the transplant is performed; and, (b) temporary lodging at a prearranged location up to $75 per day during the *covered person's confinement* in a *hospital*. Transportation costs for the *covered person's* immediate *family member(s)* or companion(s) to and from the *hospital* where the transplant is performed will be paid at: (a) 80% of *covered expenses*, subject to *deductible*, if the transplant is received at a PAR *hospital* designated by the *Plan Manager* as an approved transplant facility; or, (b) 60% of *covered expenses*, subject to *deductible*, if the transplant is received at a Non-PAR *hospital*. These direct, non-medical costs are only available if the *covered person's* immediate *family member(s)* or companion(s) live more than 100 miles from the transplant facility.*

Please contact the Transplant Management Department at our toll-free number (866) 421-5663 when in need of these *services*.

*All direct, non-medical expenses for the *covered person* receiving the transplant and his/her *family member(s)* are limited to a combined *maximum benefit* of $10,000 per transplant.

LIMITATIONS AND EXCLUSIONS

The Plan does not provide benefits for:

1. *Services*:

    a. Not furnished by a *qualified practitioner* or *qualified treatment facility*;

    b. Not authorized or prescribed by a *qualified practitioner*;

    c. Not covered by this Plan whether or not prescribed by a *qualified practitioner*;

    d. Which are not provided;

    e. For which no charge is made, or for which *you* would not be required to pay if *you* were not covered under this Plan unless charges are received from and reimbursable to the United States Government or any of its agencies as required by law; or

    f. Furnished by or payable under any plan or law through any government or any political subdivision (this does not include *Medicare* or Medicaid);

    g. Furnished for a military service connected *sickness* or *bodily injury* by or under an agreement with a department or agency of the United States Government, including the Department of Veterans Affairs;

    h. Performed in association with a *service* that is not covered under this Plan;

    i. Performed as a result of a complication arising from a *service* that is not covered under this Plan;

2. Routine eye exams, *services* to correct eye refractive disorders, eyeglass frames and lenses or contact lenses, the fitting or repair of eyeglass frames and lenses or contact lenses, unless specifically covered under this Plan;

3. Routine hearing exams, tests or screenings, other than the screening of a newborn in the hospital, *hearing aids*, the fitting or repair of *hearing aids*, unless specifically covered under this Plan. Audiograms and audiometric *services*, unless related to the diagnosis or management of a specific illness or traumatic injury, if otherwise covered.

4. Physical exams/immunizations except as otherwise provided, *services*, supplies, or other care for routine or periodic physical examinations, immunizations, or tests for screening purposes required by third parties, such as for employment, licensing, travel, school (except approved well visits), insurance, marriage, adoption, participation in athletics, or *services* conducted for medical research or examinations required by a court;

5. Elective abortions, unless the pregnancy is a life-threatening physical condition of the covered female person;

Limitations and Exclusions Continued

6. *Services* related to gender change;

7. *Services* for a reversal of sterilization;

8. *Services*, supplies, or other care for *cosmetic surgery*, and/or complications arising directly from the cosmetic *services*. Cosmetic *services* means surgical procedures performed to improve a *covered person's* appearance or to correct a deformity without restoring physical bodily function, unless *medically necessary*. The presence of a psychological condition does not make a cosmetic service *medically necessary* and will not entitle a *covered person* to coverage for cosmetic *services*. Examples of exclusions include, but are not limited to, removal of tattoos, scars, wrinkles or excess skin; plastic *surgery*; silicone injections or implants; electrolysis; wigs, including those used as cranial prosthesis; treatment of male pattern baldness; revision of previous elective procedures; keloids; pharmaceutical regimes; nutritional procedures or treatments; rhinoplasty; epikeratophakia *surgery*; skin abrasions which are performed as a treatment for acne;

9. Dental *services* except as otherwise specifically provided, *services*, supplies, or other care for dental *services* and procedures involving tooth structures, extractions, gingival tissues, alveolar processes, dental x-rays (other than for an accidental injury), procedures of dental origin, odontogenic cysts/tumors, or any orthodontic, or periodontic treatment regardless of medical necessity, except that hospital *services* may be covered provided such *services* are pre-certified as *medically necessary* to safeguard the health of the covered person from the effects or side effects of a dental procedure due to a specific non-dental organic impairment. *Services* and supplies for maxillary and/or mandibular augmentation/implant procedures to facilitate the use of full or partial dental prosthesis, fixed or removable;

10. Any loss caused by or contributed to:

    a. War or any act of war, whether declared or not, or

    b. Any act of armed conflict, or any conflict involving armed forces of any authority;

11. Any drug, medicine or device which does not have the United States Food and Drug Administration formal market approval through a New Drug Application, Premarket Approval, 510K, or PLA;

12. Any *service* which is *experimental, investigational or for research purposes;*

Limitations and Exclusions Continued

13. *Pre-existing conditions* to the extent specified in the Definitions section;

14. *Custodial care* services, supplies, or other care rendered by or in: (a) rest homes; (b) health resorts; (c) homes for the aged; (d) places primarily for domiciliary or custodial care; and (e) self-help training or other forms of non-medical self-care;

15. *Services* provided by a person who ordinarily resides in *your* home or who is a *family member*;

16. Charges in excess of the *maximum allowable fee* for the *service*;

17. Any *expense incurred* prior to *your effective date* under the Plan or after the date *your* coverage under the Plan terminates, except as specifically described in this Plan;

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

19. *Services* not *medically necessary* for diagnosis and treatment of a *bodily injury* or *sickness*;

20. Private duty nursing;

21. *Expenses incurred* for which *you* are entitled to receive benefits under *your* previous dental or medical plan;

22. All fertility testing or *services* (other than diagnostic testing or *services*), including any artificial means to achieve pregnancy or ovulation, such as artificial insemination, in vitro fertilization, spermatogenesis, gamete intra fallopian transfer (GIFT), zygote intra fallopian transfer (ZIFT), tubal ovum transfer, embryo freezing or transfer and sperm banking;

23. Therapy and testing for treatment of allergies, including but not limited to, skin titration (Rinkel Test), cytotoxicity testing (Bryan's Test), urine auto injection, provocative and neutralization testing for allergies, or for an assessment of IgG antibodies in food allergies, *services* related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts, neutralization test and/or treatment UNLESS such therapy or testing is approved by:

    a. The American Academy of Allergy and Immunology, or

    b. The Department of Health and Human Services or any of its offices or agencies;

Limitations and Exclusions Continued

24. Professional pathology or radiology charges, including but not limited to, blood counts, multi-channel testing, and other clinical chemistry tests, when:

    a. The *services* do not require a professional interpretation, or

    b. The *qualified practitioner* did not provide a specific professional interpretation of the test results of the *covered person*;

25. *Prescription* drugs, except as provided through the Pharmacy Benefit Manager's Summary Plan Description;

26. *Services* related to the treatment and/or diagnosis of sexual dysfunction/impotence;

27. *Services* for the treatment of obesity, unless specifically indicated in Other Covered Expenses section. Any *surgery* for the removal of excess fat or skin following weight loss due to obesity, *surgery*, or pregnancy, regardless of *medical necessity*, or services at a health spa or similar facility. *Services*, supplies, or other care for gastric bubble/gastric balloon procedures, stomach stapling, wiring of the jaw, liposuction and jejunal bypasses. Dietary supplements, diet pills and appetite suppressants;

28. No benefits are payable under this provision for *services* performed at a Residential Treatment Facility**;**

29. Vision therapy;

30. Smoking cessation products, except as provided through the Pharmacy Benefit Manager;

31. Birth control pills, except as provided through the Pharmacy Benefit Manager's Summary Plan Description;

32. Removal of the implant systems, except when *medically necessary*;

33. *Services*, supplies and other care for acupuncture, anesthesia by hypnosis, or anesthesia charges for *services* not covered by this plan;

Limitations and Exclusions Continued

34. *Services*, supplies, or other care provided for conditions related to conduct disorders (except attention deficit disorders), pervasive developmental disorders (except *autism)*, behavioral disorders, learning disabilities and disorders, or mental retardation. *Services*, supplies or other care for non-chemical addictions such as gambling, sexual, spending, shopping and working addictions, codependency, or caffeine addition. Milieu therapy, marriage counseling, *inpatient* admissions for environmental change, biofeedback, neuromuscular re-education, hypnotherapy, sleep therapy, vocational rehabilitation, sensory integration, educational therapy and recreational therapy, except for such adjunct *services* as part of the *inpatient* stay and required by the Joint Commission on Accreditation of Healthcare Organizations or the Commission of Accreditation of Rehabilitative Facilities;

35. Disposable supplies, normally purchased in an over the counter setting, to an *outpatient* facility including, but not limited to, ace bandages, support hosiery, pressure garments, elastic stockings, and band-aids;

36. Modifications to *your* home or place of business, such as ramps, air conditioners, seat lift chairs or supplies or attachments for any of these items; penile implants; professional medical equipment such as blood pressure kits; purchase or rental of escalators or elevators; spas, saunas or swimming pools. Any *durable medical equipment*, prosthesis, or orthotic device having convenience or luxury features which are not *medically necessary*, except that benefits for the cost of standard equipment or device used in the treatment of disease, Illness, or injury will be provided toward the cost of any deluxe equipment, prosthetic or device selected. Benefits are excluded for the repair, maintenance and/or replacement of *durable medical equipment*, except as otherwise provided. Vehicle adjustments, air purifiers, free-standing humidifiers, dehumidifiers, stair-gliders, *Emergency* Alert equipment, handrails, heat appliances, waterbeds, whirlpool baths, exercise and massage equipment;

37. *Services* or supplies for routine foot care or other care used in treatment of superficial lesions of the feet such as corns, hyperkeratosis, bunions, tarsalgia, metatarsalgia (except capsular or bone *surgery*), callouses, nails of the feet (except mycotic infections or *surgery* for ingrown nails), flat feet, fallen arches, weak feet, or similar conditions, unless *medically necessary* for complications of diabetes;

38. *Services*, supplies or other care for personal hygiene, environmental control, convenience items (including, but not limited to, air conditioners, humidifiers, or physical fitness equipment), or personal comfort and convenience items (such as daily television rental, telephone services, cots or visitors' meals). Charges for:

    a. Telephone consultations;
    b. Failure to keep a scheduled visit;
    c. Completion of a *claim* form; or
    d. Providing requested information to the Plan.

39. *Services* or supplies provided for self-help training or other form of non-medical self-care. Purchase or rental of supplies of common household use such as exercise cycles, air purifiers, central or unit air conditioners, water purifiers, allergenic pillows or mattresses or waterbeds, treadmill or special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program. *Services* or supplies at a health spa or similar Facility;

Limitations and Exclusions Continued

40. Food, food supplements (except special formulas *medically necessary* for the treatment of certain inborn errors of metabolism including PKU), minerals, vitamins, or drugs which could be purchased without a written prescription, or are not FDA approved for treatment of a specified category of medical conditions, or are not *medically necessary*, or are considered to be *experimental* or *investigational*, except as provided through the Pharmacy Benefit Manager's Summary Plan Description;

41. *Services*, supplies, or other care to the extent that benefits or reimbursement are available from or provided by any other group coverage, except that the Plan will coordinate the payment of benefits under this plan with such other coverage, as permitted by Kentucky Law;

42. Chelation therapy except in the treatment of lead or other heavy metal poisoning;

43. *Services*, supplies, or other care for educational or training procedures used in connection with speech except as otherwise defined in the Covered Services Section (Therapy Services), hearing, or vision *services*;

44. *Services*, supplies, or other care provided to an inpatient solely for cardiac rehabilitation. *Services*, supplies, or other care provided for non-human, artificial, or mechanical hearts or ventricular and/or atrial assist devices used as a heart replacement (when not otherwise provided in conjunction with a human organ transplant) and supportive *services* or devices in connection with such care. This exclusion includes *services* for implantation, removal, and complications;

45. Food, housing, home delivered meals, and homemaker services (such as housekeeping, laundry, shopping and errands). Teaching household routine to members of the *covered person's* family; supervision of a *covered person's* children; and other similar functions. Benefits are not provided for home health care education beyond the normal and customary period for learning. Supportive environmental materials, including hand rails, ramps, telephones, air conditioners and similar items. *Services* or supplies provided by the family of the *covered person* or volunteer ambulance associations. Visiting teachers, friendly visitors, vocational guidance, and other counselors. *Services* related to diversional and social activities. *Services* for which there is no cost to the *covered person*;

46. *Hospice services*, supplies, or other care except as covered by *Medicare's hospice* benefit;

47. Inpatient Diagnostic/Therapy – Non-emergency diagnostic admissions for inpatients or admissions primarily for therapy *services*, unless pre-authorized by the *Plan*;

48. *Services*, supplies, and other care related to suction-assisted lipectomy or diastasis recti repair, including instances when diastasis recti is associated with an umbilical or ventral hernia;

Limitations and Exclusions Continued

49. *Services*, supplies, or other care to the extent that Medicare is the primary payer. The Plan will coordinate the payment of benefits under this *plan* with Medicare, as permitted by Kentucky and Federal law;

50. *Services* or supplies for *mental health conditions* unless performed by a *physician* or other *provider* who is licensed or certified by the Commonwealth of Kentucky (or a corresponding licensing or certifying authority when the service is provided outside of the Commonwealth). *Services* for *mental health conditions* when provided for purposes of medical, educational, or occupational training. Psychological testing beyond that necessary to establish a diagnosis or beyond that approved by the subcontractor;

51. *Services*, supplies, or other care not meeting a *Plan's plan delivery system rules*.

52. Drugs that can be purchased without a written prescription. Amino acid modified preparations and low-protein modified food products for the treatment of lactose intolerance, protein intolerance, food allergy, food insensitivity, for any condition not listed in subparagraph (D) in Section 140.12 under prescription drugs and medical supplies, except as provided through the Pharmacy Benefit Manager's Summary Plan Description;

53. Travel or transportation expenses (except *ambulance*), even though prescribed by a physician. Air ambulance is excluded, unless emergency medical *services*, the attending physician, or the Plan determines an air *ambulance* is the only medically appropriate means of transportation to the nearest appropriate facility.

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

OPEN ENROLLMENT

Once annually *you* will have a choice of enrolling *yourself* and *your* eligible *dependents* in this Plan. *You* will be notified in advance when the open enrollment period is to begin and how long it will last. If *you* decline coverage for yourself or *your dependents* at the time *you* are initially eligible for coverage, *you* will be able to enroll yourself and/or eligible *dependents* during the Open Enrollment Period. *Your* coverage will be subject to the *pre-existing condition* limitation.

EMPLOYEE ELIGIBILITY

You are eligible for coverage if the following conditions are met:

1. *You* are an *employee* or *retiree* who meets the eligibility requirements of the *employer*; and

2. *You* participate in a state-sponsored retirement systems.

Your eligibility date is as determined by the *employer*.

EMPLOYEE EFFECTIVE DATE OF COVERAGE

You must enroll on forms acceptable to the Plan Sponsor.

1. If *your* completed enrollment forms are signed by *you* within 30 days after *your* eligibility date, *your* coverage is effective on the 1st day of the 2nd month following hire date. *Your* coverage may be effective at a later date as determined by the *employer*.
2. If *your* completed enrollment forms are signed by *you* more than 30 days after *your* eligibility date, *you* are a *late applicant* and *you* will not be eligible for coverage under this Plan until the next annual open enrollment period or until *you* experience a permitted *qualifying event*. *Your* coverage is effective as determined by the *employer*.
3. *You* may have a waiting period longer than the 1st day of the 2nd month following hire date. Contact *your* agency's health Insurance Coordinator for details. However, regardless of *your* employer's regulations regarding effective dates of coverage, *your* enrollment forms must be signed at least 30 days prior to the coverage effective date.

DEPENDENT ELIGIBILITY

A *dependent* will be effective as outlined in the Dependent Effective Date of Coverage section.

Each *dependent* is eligible for coverage on:

1. The date the *employee* is eligible for coverage, if he or she has *dependents* who may be covered on that date; or

2. The date of birth of the *employee's* natural-born child; or

3. The date a child is placed for adoption under the *employee's* legal guardianship, or the date which the *employee* incurs a legal obligation for total or partial support in anticipation of adoption; or

Eligibility and Effective Date of Coverage Continued

4. The date a covered *employee's* child is determined to be eligible as an alternate recipient under the terms of a medical child support order.

The covered *employee* may cover *dependents* only if the *employee* is also covered. Check with *your employer* immediately on how to enroll for *dependent* coverage. Late enrollment will result in denial of *dependent* coverage until the next annual open enrollment period.

In any event, no person may be simultaneously covered as both an *employee* and a *dependent*. If both parents are eligible for coverage, the *dependent* may only enroll under one *Plan*.

DEPENDENT EFFECTIVE DATE OF COVERAGE

If the *employee* wishes to add to the *Plan* a newborn *dependent* only an enrollment form must be completed and submitted to the Plan Sponsor.

The newborn *dependent's* effective date of coverage is determined as follows:

1. If the completed enrollment forms are signed by *you* within 60 days after the newborn *dependent's* eligibility date, that newborn *dependent* is covered on the date he or she is eligible.

2. If the completed enrollment forms are signed by *you* more than 60 days after the newborn *dependent's* eligibility date, the newborn *dependent* is a *late applicant*. The newborn *dependent* will not be eligible for coverage under this Plan until the next annual open enrollment period.

Newborn *dependents* will be covered for an initial period of thirty-one (31) days from the date of birth. Coverage for newborns will continue beyond thirty-one (31) days only if the *employee* completes and submits a signed enrollment form within the timeframe outlined above.

If the *employee* wishes to add to the *Plan* a *dependent* (other than a newborn) in addition to the newborn *dependent* an enrollment form must be completed and submitted to the Plan Sponsor.

The *dependent's* effective date of coverage is determined as follows:

1. If the completed enrollment forms are signed by *you* within 30 days after the newborn *dependent's* date of birth, that newborn *dependent* and *dependent* (other than a newborn) are covered on the date he or she is eligible.

2. If the completed enrollment forms are signed by *you* more than 30 days after the newborn *dependent's* date of birth, the newborn *dependent* and the *dependent* (other than a newborn) is a *late applicant*. The newborn *dependent* and the *dependent* (other than a newborn) will not be eligible for coverage under this Plan until the next annual open enrollment period.

If the *employee* wishes to add a *dependent* (other than a newborn) to the Plan the *dependent's effective date* of coverage is determined as follows:

1. If the completed enrollment forms are signed by *you* within 30 days after the *dependent's* eligibility date, that *dependent* is covered on the date he or she is eligible.

Eligibility and Effective Date of Coverage Continued

2. If the completed enrollment forms are signed by *you* more than 30 days after the *dependent's* eligibility date, the *dependent* is a *late applicant*. The *dependent* will not be eligible for coverage under this Plan until the next annual open enrollment period. The *dependent* is covered as determined by the *employer*.

No *dependent's effective date* will be prior to the covered *employee's effective date* of coverage. If *your dependent* child becomes an eligible *employee* of the *employer* or becomes an employee of another employer, he or she may no longer be eligible as *your dependent* under this Plan. Please refer to the definition section for *dependent* requirements.

FAMILY CROSS-REFERENCE PAYMENT OPTION

To be eligible to elect the cross-reference payment option, each of the following requirements must be met:

- the *members* must be legally married (husband and wife);
- the *members* must be eligible *employees* or *retirees** of a group participating in the *Kentucky Employees Health Plan*;
- the *members* must elect the same coverage; and
- both *members* must sign the appropriate documentation during the enrollment process and file with their agency's Insurance Coordinators. If during Open Enrollment *you* enroll online, *you* will be required to enter both *members*' passwords via the web.

Failure to meet any one of the above requirements means that *you* are not eligible for the cross-reference payment option.

* *Members* of the Judicial and Legislators Retirement Plans are not eligible to elect the cross-reference payment option.

TERMINATING EMPLOYMENT WITH CROSS-REFERENCE PAYMENT OPTION

Employees will not be eligible to continue the cross-reference payment option if one spouse terminates employment. The cross-reference payment option will terminate automatically and the remaining *employee* will be responsible for the payment of the family contribution. Although, the terminating *employee* is no longer eligible to receive an *employer* contribution, they are covered by a family plan and will not experience a loss of coverage.

MEDICAL CHILD SUPPORT ORDERS

An individual who is a child of a covered *employee* shall be enrolled for coverage under the Plan in accordance with the direction of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSN).

A QMCSO is a state court order or judgment, including approval of a settlement agreement that: (a) provides for support of a covered *employee's* child; (b) provides for health care coverage for that child; (c) is made under state domestic relations law (including a community property law); (d) relates to benefits under the Plan; and (e) is "qualified" in that it meets the technical requirements of ERISA or applicable state law. QMCSO also means a state court order or judgment that enforces a state Medicaid law regarding medical child support required by Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993).

An NMSN is a notice issued by an appropriate agency of a state or local government that is similar to a QMCSO that requires coverage under the Plan for the *dependent* child of a non-custodial parent who is (or will become) a *covered person* by a domestic relations order that provides for health care coverage.

Procedures for determining the qualified status of medical child support orders are available at no cost upon request from the Plan Administrator.

PRE-EXISTING CONDITION LIMITATION

Benefits for *pre-existing conditions* are limited under the Plan. *Pre-existing condition* is defined in the Definitions section of this booklet.

Once *you* or *your dependents* obtain health plan coverage, *you* are entitled to use evidence of that coverage to reduce or eliminate any *pre-existing condition* limitation period that might otherwise be imposed when *you* become covered under a subsequent health plan. Evidence may include a *certificate* of prior *creditable coverage*. The length of any *pre-existing condition* limitation period under the subsequent health plan must be reduced by the number of days of *creditable coverage*.

Prior to imposing a *pre-existing condition* limitation, the *Plan Manager* will:

1. Notify *you* in writing of the existence and terms of any *pre-existing condition* limitation;

Eligibility and Effective Date of Coverage Continued

2. Notify *you* of *your* right to request a *certificate* of *creditable coverage* from any applicable prior plans;

3. Notify *you* of *your* right to submit evidence of *creditable coverage* to the *Plan Manager* to reduce the length of any *pre-existing condition* limitation; and

4. Offer to request a *certificate* of prior *creditable coverage* on *your* behalf.

If, after receiving evidence of *creditable coverage*, the *Plan Manager* determines the *creditable coverage* is not sufficient to completely offset the Plan's *pre-existing condition* limitation period, the *Plan Manager* will:

1. Notify *you* in writing of its determination;

2. Notify *you* of the source and substance of any information on which it relied; and

3. Provide an explanation of appeal procedures and allow a reasonable opportunity to submit additional evidence of *creditable coverage*.

The *Plan Manager* may modify an initial determination of *creditable coverage* if it determines the individual did not have the claimed *creditable coverage*, provided the *Plan Manager*:

1. Notifies *you* of such reconsideration in writing disclosing its determination;

2. Notifies *you* with the source and substance of any information on which it relied; and

3. Provides an explanation of appeal procedures and allows a reasonable opportunity to submit additional evidence of *creditable coverage*.

Alternate means of providing evidence of *creditable coverage* may include an explanation of benefits, correspondence from a plan, pay stubs showing a payroll deduction of *premium* for health plan coverage, third party statements verifying period(s) of coverage, information obtained by telephone, and any other relevant document providing evidence of period(s) of health coverage.

The *pre-existing condition* limitation does not apply to:

1. pregnancy;

2. genetic information in the absence of diagnosis;

3. domestic violence; or

4. newborn children, or children adopted before the age of 18, if they are covered under the Plan within 60 days of the date of birth, the date the child is legally adopted, or the date the child is legally placed for adoption.

SPECIAL PROVISIONS FOR NOT BEING IN ACTIVE STATUS

If *your employer* continues to pay required contributions and does not terminate the Plan, *your* coverage will remain in force for:

1. No longer than the end of the next month following the part-time status begin date; or

2. No longer than the end of the next month following the approved leave of absence begin date; or

3. No longer than the end of the next month following the layoff begin date; or

4. No longer than the end of the month in which a *covered person* is activated during an approved military leave of absence; or

5 No longer than the end of the next month following the approved medical leave of absence (other than FMLA) begin date; or

6. No longer than the end of the next month following the period of *total disability* begin date.

REINSTATEMENT OF COVERAGE FOLLOWING INACTIVE STATUS

If *your* coverage under the Plan was terminated after a period of layoff, *total disability*, or during part-time status, and *you* are now returning to work, *your* coverage is effective the first day of the second month *you* return to work. Both the eligibility period requirement and the *pre-existing condition* limitation will be waived with respect to the reinstatement of *your* coverage. If there is a 63-day lapse in coverage, *pre-existing condition* limitation will be imposed.

If *your* coverage under the Plan was terminated after a period of an approved leave of absence without pay, and *you* are now returning to work, *your* coverage is effective the first day of the next month *you* return to work. The eligibility period requirement will be waived and the *pre-existing condition* limitation will be imposed with respect to the reinstatement of *your* coverage.

If *your* coverage under the Plan was terminated after a period of an approved military leave of absence (other than USERRA), and *you* are now returning to work, *your* coverage is effective immediately on the day *you* return to work, unless the *employee* waits until Tricare terminates. Both the eligibility period requirement and the *pre-existing condition* limitation will be waived with respect to the reinstatement of *your* coverage.

If *your* coverage under the Plan was terminated due to a period of service in the uniformed services covered under the Uniformed Services Employment and Reemployment Rights Act of 1994, *your* coverage is effective immediately on the day *you* return to work. Eligibility *waiting periods* and *pre-existing condition* limitations will be imposed only to the extent they were applicable prior to the period of service in the uniformed services.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

If *you* are granted a leave of absence (Leave) by the *employer* as required by the Federal Family and Medical Leave Act, *you* may continue to be covered under the Plan for the duration of the Leave under the same conditions as other *employees* who are in *active status* and covered by the Plan. If *you* choose to terminate coverage during the Leave, or if coverage terminates as a result of nonpayment of any required contribution, coverage may be reinstated on the date *you* return to *active status* immediately following the end of the Leave. Charges incurred after the date of reinstatement will be paid as if *you* had been continuously covered.

EXTENDED BENEFITS

If, on the date *your* coverage terminates under the *Plan*, *you* or *your* covered *dependents* are *totally disabled* as a result of a covered *bodily injury* or *sickness*, the *Plan* will continue to provide medical benefits until the earliest of the following:

1. Until coverage for the *total disability* has been obtained under another group policy; or

2. The date *your physician* certifies *you* are no longer *totally disabled*; or

3. The date *you* receive benefits equal to any *maximum benefit* shown on the Schedule of Benefits; or

4. The end of twelve consecutive months immediately following the date of *your* termination of coverage. This period of time is measured from the date *your* coverage is terminated under the *Plan*, to the same calendar day of the next succeeding months.

The Extended Benefits provision applies only to *covered expenses* for the disabling condition which existed on the date *your* coverage terminated. The *Plan* must remain in effect.

RETIREE COVERAGE

If *you* are a *retiree* who is under age 65 or is age 65 or older and non-*Medicare* eligible, *you* may enroll or continue coverage under the Plan for *you* and any of *your* eligible *dependents*. Please see *your* retirement system for more details.

SURVIVORSHIP COVERAGE

If the *employee* dies while *dependent* coverage is in force, the surviving *dependent spouse* and *dependent* children may continue to be covered through the COBRA provision. Coverage may continue as long as the *premium* is paid, until the earliest of the following:

1. for the surviving *dependent spouse*, attaining age 65 and Medicare eligible;

2. for a *dependent* child, the date a limiting age is attained;

3. for any *dependent*, the date eligible for other group insurance;

4. the date this policy terminates or the date the *employer* terminates participation under this Plan.

Eligibility and Effective Date of Coverage Continued

When a surviving *dependent spouse* is covered under the Kentucky Teachers' Retirement System (KTRS) coverage will continue until the surviving *dependent* spouse remarries or becomes age 65 and Medicare eligible. When a surviving *dependent spouse* is covered under the Kentucky Retirement System (KRS) coverage continues to age 65 and Medicare eligible.

When a surviving *dependent spouse* is covered under KTRS, *dependents* acquired through remarriage are not eligible. When a surviving *dependent spouse* is covered under KRS, *dependents* acquired through remarriage may be added by timely enrollment. Please see *your* retirement system for more details.

SPECIAL ENROLLMENT

If *you* previously declined coverage under this Plan for *yourself* or any eligible *dependents*, due to the existence of other health coverage (including COBRA), and that coverage is now lost, this Plan permits *you*, *your dependent spouse*, and any eligible *dependents* to be enrolled for medical benefits under this Plan due to any of the following *qualifying events*:

1. Loss of coverage due to any of the following:

    a. Legal separation or annulment;
    b. Divorce;
    c. Cessation of *dependent* status (such as attaining the limiting age);
    d. Death;
    e. Termination of employment;
    f. Reduction in the number of hours of employment;
    g. Any loss of coverage after a period that is measured by reference to any of the foregoing.
    h. Meeting or exceeding a lifetime limit on all benefits;
    i. Plan no longer offering benefits to a class of similarly situated individuals, which includes the *employee.*

    However, loss of coverage does not include a loss due to failure of the individual or the participant to pay *premiums* on a timely basis or termination of coverage for cause (such as making a fraudulent *claim* or an intentional misrepresentation of a material fact in connection with the plan).

2. *Employer* contributions towards the other coverage have been terminated. *Employer* contributions include contributions by any current or former *employer* (of the individual or another person) that was contributing to coverage for the individual.

3. COBRA coverage under the other plan has since been exhausted.

Eligibility and Effective Date of Coverage Continued

If *you* are a covered *employee* or an otherwise eligible *employee***,** who either did not enroll or did not enroll *dependents* when eligible, *you* now have the opportunity to enroll *yourself* and/or any previously eligible *dependents* or any newly acquired *dependents* when due to any of the following family status changes:

1. Marriage;

2. Birth; or

3. Adoption or placement for adoption.

You may elect coverage under this Plan provided enrollment is within 30 days from the *qualifying event* or as listed in the Dependent Effective Date of Coverage section. *You* may be required to provide proof that the *qualifying event* has occurred due to one of the reasons listed before coverage under this Plan will be effective. Coverage under this Plan will be effective the 1st day of the month following the signature date of the enrollment form, unless otherwise specified in this section.

In the case of a *dependent's* birth, enrollment is effective on the date of such birth provided the appropriate paperwork is received.

In the case of a *dependent's* adoption or placement for adoption, enrollment is effective on the date of such adoption or placement for adoption, provided the appropriate paperwork is received.

If *you* become eligible for coverage under this Plan through the special enrollment provision, benefits under the Plan will be subject to the *pre-existing condition* limitation as defined within the Definitions section of this booklet.

If *you* apply more than 30 days after a *qualifying event* or as listed in the Dependent Effective Date of Coverage section, *you* are considered a *late applicant* and will not be eligible for coverage under this Plan until the next annual open enrollment period.

Please refer to Exhibit A at the end of this document or see *your employer* for more details.

COVERAGE TERMINATION DUE TO PLAN CHANGE

If an *employee* or *dependent* changes Insurance Carriers during Open Enrollment, the existing coverage with the prior Insurance Carrier will terminate on December 31, except for the following:

1. If a covered *member* is hospitalized when coverage would normally terminate, the prior Insurance Carrier that covered the *member's* hospitalization during the previous plan year would continue coverage until the *member* is released from the *hospital* or transferred to another facility. At the time the *member* is released from the *hospital* or transferred to a new facility, the succeeding Insurance Carrier will assume responsibility for that *member*. It is the *member's* responsibility to ensure that a transfer or re-hospitalization is to a participating facility in compliance with all Plan delivery rules.

Eligibility and Effective Date of Coverage Continued

2. If a *member* has family coverage and a covered *dependent* is hospitalized when coverage would normally terminate due to a change in Insurance Carriers, the hospitalized family member would continue his/her prior coverage until discharge from the *hospital* or transfer to another facility. All other covered *dependents* not hospitalized at the date the new coverage begins would be transferred to the new Plan on the date the new coverage starts (not on the date the hospitalized *dependent* is released or transferred.

3. If a covered *member* is not at work and/or is on unofficial leave without pay or otherwise continuing to pay for his/her own health insurance premiums on the group coverage, that participant will begin coverage with his/her succeeding Insurance Carrier on January 1, even though he/she is not at work.

These provisions take precedence over all Extension of Benefits clauses and Actively at Work clauses contained in any of the Insurance Carrier's standard commercial contracts in compliance with KRS 304.18-126 and KRS 304.18-127.

TERMINATION OF COVERAGE

Coverage terminates on the earliest of the following:

1. The date the Plan terminates;

2. The end of the period for which any required contribution was due and not paid;

3. The date *you* enter full-time military, naval or air service, except coverage may continue during an approved military leave of absence as indicated in the Special Provisions For Not Being in Active Status provision;

4. The end of the month in which *you* fail to be in an eligible class of persons according to the eligibility requirements of the *employer*;

5. For all *employees*, coverage will terminate on the last day of the second month following the date in which *your* employment terminates;

6. For any benefit, the date the benefit is removed from the Plan;

7. For *your dependents*, the date *your* coverage terminates;

8. For a *dependent*, the date the *dependent* enters full-time military, naval or air service;

9. For a *dependent*, the end of the calendar month such *covered person* no longer meets the definition of *dependent*; or

10. The date *you* request termination of coverage to be effective for yourself and/or *your dependents* based on valid qualifying event guidelines.

IF *YOU* OR ANY OF *YOUR* COVERED *DEPENDENTS* NO LONGER MEET THE ELIGIBILITY REQUIREMENTS, *YOU* AND *YOUR EMPLOYER* ARE RESPONSIBLE FOR NOTIFYING THE *PLAN MANAGER* OF THE CHANGE IN STATUS. COVERAGE WILL NOT CONTINUE BEYOND THE END OF THE MONTH IN WHICH ELIGIBILITY ENDS EVEN IF NOTICE HAS NOT BEEN GIVEN TO THE *PLAN MANAGER*.

IMPORTANT NOTICE FOR EMPLOYEES AND SPOUSES AGE 65 AND OVER

Federal law may affect *your* coverage under this Plan. The *Medicare* as Secondary Payer rules were enacted by an amendment to the Social Security Act. Also, additional rules which specifically affect how a large group health plan provides coverage to employees (or their *spouses*) over age 65 were added to the Social Security Act and to the Internal Revenue Code.

Generally, the health care plan of an employer that has at least 20 employees must operate in compliance with these rules in providing plan coverage to plan participants who have "current employment status" and are *Medicare* beneficiaries, age 65 and over.

Persons who have "current employment status" with an employer are generally employees who are actively working and also persons who are NOT actively working as follows:

- Individuals receiving disability benefits from an employer for up to 6 months, or

- Individuals who retain employment rights and have not been terminated by the employer and for whom the employer continues to provide coverage under this Plan. (For example, employees who are on an approved leave of absence.)

If *you* are a person having "current employment status" who is age 65 and over (or the *dependent spouse* age 65 and over of an *employee* of any age), *your* coverage under this Plan will be provided on the same terms and conditions as are applicable to *employees* (or *dependent spouses*) who are under the age of 65. *Your* rights under this Plan do not change because *you* (or *your dependent spouse*) are eligible for *Medicare* coverage on the basis of age, as long as *you* have "current employment status" with *your employer*.

You have the option to reject plan coverage offered by *your employer*, as does any eligible *employee*. If *you* reject coverage under *your employer's* Plan, coverage is terminated and *your employer* is not permitted to offer *you* coverage that supplements *Medicare covered services.*

If *you* (or *your dependent spouse*) obtain *Medicare* coverage on the basis of age, and not due to disability or end-stage renal disease, this Plan will consider its coverage to be primary to *Medicare* when *you* have elected coverage under this Plan and have "current employment status".

If *you* have any questions about how coverage under this Plan relates to *Medicare* coverage, please contact *your Medicare* office.

CONTINUATION OF MEDICAL BENEFITS

THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1986 (COBRA)

CONTINUATION OF BENEFITS

On April 7, 1986, the Consolidated Omnibus Budget Reconciliation Act (COBRA) was signed into law. This federal law applies to employers with 20 or more employees. The law requires that employers offer employees and/or their *dependents* continuation of medical coverage at group rates in certain instances where there is a loss of group insurance coverage.

ELIGIBILITY

A qualified *beneficiary* under COBRA law means an *employee*, *employee's spouse* or *dependent* child covered by the Plan on the day before a *qualifying event*. A qualified *beneficiary* under COBRA law also includes a child born to the *employee* during the coverage period or a child placed for adoption with the *employee* during the coverage period.

EMPLOYEE: An *employee* covered by the *employer's* Plan has the right to elect continuation coverage if coverage is lost due to one of the following *qualifying events*:

- Termination (for reasons other than gross misconduct) of the *employee's* employment or reduction in the hours of *employee's* employment; or
- Termination of *retiree* coverage when the former *employer* discontinues *retiree* coverage within one year before or one year after filing for Chapter 11 bankruptcy.

SPOUSE: A *spouse* covered by the *employer's* Plan has the right to elect continuation coverage if the group coverage is lost due to one of the following *qualifying events*:

- The death of the *employee*;
- Termination of the *employee's* employment (for reasons other than gross misconduct) or reduction of the *employee's* hours of employment with the *employer*;
- Divorce or legal separation from the *employee*;
- The *employee* becomes entitled to *Medicare* benefits; or
- Termination of a *retiree spouse's* coverage when the former *employer* discontinues *retiree* coverage within one year before or one year after filing for Chapter 11 bankruptcy.

DEPENDENT CHILD: A *dependent* child covered by the *employer's* Plan has the right to continuation coverage if group coverage is lost due to one of the following *qualifying events*:

- The death of the *employee*-parent;
- The termination of the *employee*-parent's employment (for reasons other than gross misconduct) or reduction in the *employee*-parent's hours of employment with the *employer*;
- The *employee*- parent's divorce or legal separation;
- Ceasing to be a "*dependent* child" under the Plan;
- The *employee*-parent becomes entitled to *Medicare* benefits; or
- Termination of the *retiree*-parent's coverage when the former *employer* discontinues *retiree* coverage within one year before or one year after filing for Chapter 11 bankruptcy.

COBRA Continued

LOSS OF COVERAGE

Coverage is lost in connection with the foregoing qualified events, when a covered *employee*, *spouse* or *dependent* child ceases to be covered under the same Plan terms and conditions as in effect immediately before the *qualifying event* (such as an increase in the *premium* or contribution that must be paid for *employee*, *spouse* or *dependent* child coverage).

If coverage is reduced or eliminated in anticipation of an event (for example, an *employer* eliminating an *employee's* coverage in anticipation of the termination of the *employee's* employment, or an *employee* eliminating the coverage of the *employee's spouse* in anticipation of a divorce or legal separation), the reduction or elimination is disregarded in determining whether the event causes a loss of coverage.

A loss of coverage need not occur immediately after the event, so long as it occurs before the end of the Maximum Coverage Period.

NOTICES AND ELECTION

The Plan provides that coverage terminates, for a *spouse* due to legal separation or divorce or for a child when that child loses *dependent* status. Under the law, the *employee* or qualified *beneficiary* has the responsibility to inform the Plan Administrator (see Plan Description Information) if one of the above events has occurred. The qualified *beneficiary* must give this notice within 60 days after the event occurs. (For example, an ex-*spouse* should make sure that the Plan Administrator is notified of his or her divorce, whether or not his or her coverage was reduced or eliminated in anticipation of the event). When the Plan Administrator is notified that one of these events has happened, it is the Plan Administrator's responsibility to notify the *Plan Manager* who has contracted with a *COBRA Service Provider* who will in turn notify the qualified *beneficiary* of the right to elect continuation coverage.

For a qualified *beneficiary* who is determined under the Social Security Act to be disabled at any time during the first 60 days of COBRA coverage, the continuation coverage period may be extended 11 additional months. The disability that extends the 18-month coverage period must be determined under Title II (Old Age, Survivors, and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act. To be entitled to the extended coverage period, the disabled qualified *beneficiary* must provide notice to the *COBRA Service Provider* within the initial 18 month coverage period and within 60 days after the date of the determination of disability under the Social Security Act. Failure to provide this notice will result in the loss of the right to extend the COBRA continuation period.

For termination of employment, reduction in work hours, the death of the *employee*, the *employee* becoming covered by *Medicare* or loss of *retiree* benefits due to bankruptcy, it is the Plan Administrator's responsibility to notify the *Plan Manager* who has contracted with a *COBRA Service Provider* who will in turn notify the qualified *beneficiary* of the right to elect continuation coverage.

Under the law, continuation coverage must be elected within 60 days after Plan coverage ends, or if later, 60 days after the date of the notice of the right to elect continuation coverage. If continuation coverage is not elected within the 60 day period, the right to elect coverage under the Plan will end.

A covered *employee* or the *spouse* of the covered *employee* may elect continuation coverage for all covered *dependents*, even if the covered *employee* or *spouse* of the covered *employee* or all covered *dependents* are covered under another group health plan (as an employee or otherwise) prior to the election. The covered *employee*, his or her *spouse* and *dependent* child, however, each have an independent right to elect continuation coverage. Thus a *spouse* or *dependent* child may elect continuation coverage even if the covered *employee* does not elect it.

COBRA Continued

Coverage will not be provided during the election period. However, if the individual makes a timely election, coverage will be provided from the date that coverage would otherwise have been lost. If coverage is waived before the end of the 60 day election period and the waiver revoked before the end of the 60 day election period, coverage will be effective on the date the election of coverage is sent to the *COBRA Service Provider*.

On August 6, 2002, The Trade Act of 2002 (TAA) was signed in to law. Workers whose employment is adversely affected by international trade (increased import or shift in production to another country) may become eligible to receive TAA. TAA provides a second 60-day COBRA election period for those who become eligible for assistance under TAA. Pursuant to the Trade Act of 1974, an individual who is either an eligible TAA recipient or an eligible alternative TAA recipient and who did not elect continuation coverage during the 60-day COBRA election period that was a direct consequence of the TAA-related loss of coverage, may elect continuation coverage during a 60-day period that begins on the first day of the month in which he or she is determined to be TAA-eligible individual, provided such election is made not later than 6 months after the date of the TAA-related loss of coverage. Any continuation coverage elected during the second election period will begin with the first day of the second election period and not on the date on which coverage originally lapsed.

TAA created a new tax credit for certain individuals who became eligible for trade adjustment assistance (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of *premiums* paid for qualified health insurance, including continuation coverage. If *you* have questions about these new tax provisions, *you* may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282.

The Plan Administrator shall require documentation evidencing eligibility of TAA benefits. The Plan need not require every available document to establish evidence of TAA. The burden for evidencing TAA eligibility is that of the individual applying for coverage under the Plan.

MAXIMUM COVERAGE PERIOD

Coverage may continue up to:

- 18 months for an *employee* and/or *dependent* whose group coverage ended due to termination of the *employee's* employment or reduction in hours of employment;
- 36 months for a *spouse* whose coverage ended due to the death of the *employee* or *retiree*, divorce, or the *employee* becoming entitled to *Medicare* at the time of the initial *qualifying event*;
- 36 months for a *dependent* child whose coverage ended due to the divorce of the *employee* parent, the *employee* becoming entitled to *Medicare* at the time of the initial *qualifying event*, the death of the *employee*, or the child ceasing to be a *dependent* under the Plan;
- For the *retiree*, until the date of death of the *retiree* who is on continuation due to loss of coverage within one year before or one year after the *employer* filed Chapter 11 bankruptcy.

COBRA Continued

DISABILITY

An 11-month extension of coverage may be available if any of the qualified beneficiaries are determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. The qualified *beneficiary* must provide notice of such determination prior to the end of the initial 18-month continuation period to be entitled to the additional 11 months of coverage. Each qualified *beneficiary* who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If a qualified *beneficiary* is determined by SSA to no longer be disabled, *you* must notify the Plan of that fact within 30 days after SSA's determination.

SECOND QUALIFYING EVENT

An 18-month extension of coverage will be available to *spouses* and *dependent* children who elect continuation coverage if a second *qualifying event* occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second *qualifying event* occurs is 36 months. Such second *qualifying event* may include the death of a covered *employee*, divorce or separation from the covered *employee*, the covered *employee's* becoming entitled to *Medicare* benefits (under Part A, Part B, or both), or a *dependent* child's ceasing to be eligible for coverage as a *dependent* under the Plan. These events can be a second *qualifying event* only if they would have caused the qualified *beneficiary* to lose coverage under the Plan if the first *qualifying event* had not occurred. *You* must notify the Plan within 60 days after the second *qualifying event* occurs if *you* want to extend *your* continuation coverage.

TERMINATION BEFORE THE END OF MAXIMUM COVERAGE PERIOD

Continuation coverage will terminate before the end of the maximum coverage period for any of the following reasons:

- The *employer* no longer provides group health coverage to any of its *employees*;
- The *premium* for continuation is not paid timely;
- The individual on continuation becomes covered under another group health plan (as an *employee* or otherwise); however, if the new plan coverage contains any exclusion or limitation with respect to any *pre-existing condition*, then continuation coverage will end for this reason only after the exclusion or limitation no longer applies or prior *creditable coverage* satisfies the exclusion or limitation;

  NOTE: the federal Health Insurance Portability and Accountability Act of 1996 requires portability of health care coverage effective for plan years beginning after June 30, 1997, an exclusion or limitation under the other group health plan may not apply at all to the qualified *beneficiary*, depending on the length of his or her prior *creditable coverage*. Portability means once *you* obtain health insurance, *you* will be able to use evidence of that insurance to reduce or eliminate any pre-existing medical condition limitation period (under certain circumstances) when *you* move from one health plan to another.

- The individual on continuation becomes entitled to *Medicare* benefits;

- If there is a final determination under Title II or XVI of the Social Security Act that an individual is no longer disabled; however, continuation coverage will not end until the month that begins more than 30 days after the determination;

- The occurrence of any event (e.g. submission of a fraudulent *claim*) permitting termination of coverage for cause under the Plan.

TYPE OF COVERAGE; PREMIUM PAYMENT

If continuation coverage is elected, the coverage must be identical to the coverage provided under the *employer's* Plan to similarly situated non-COBRA beneficiaries. This means that if the coverage for similarly situated non-COBRA beneficiaries is modified, coverage for the individual on continuation will be modified.

The initial *premium* payment for continuation coverage is due by the 45th day after coverage is elected. The initial *premium* includes charges back to the date the continuation coverage began. All other *premiums* are due on the first of the month for which the *premium* is paid, subject to a 31 day grace period. The *COBRA Service Provider* must provide the individual with a quote of the total monthly *premium*.

Premium for continuation coverage may be increased, however, the *premium* may not be increased more than once in any determination period. The determination period is a 12 month period which is established by the Plan.

The monthly *premium* payment to the Plan for continuing coverage must be submitted directly to the *COBRA Service Provider*. This monthly *premium* may include the *employee's* share and any portion previously paid by the *employer*. The monthly *premium* must be a reasonable estimate of the cost of providing coverage under the Plan for similarly situated non-COBRA beneficiaries. The *premium* for COBRA continuation coverage may include a 2% administration charge. However, for qualified beneficiaries who are receiving up to 11 months additional coverage (beyond the first 18 months) due to disability extension (and not a second *qualifying event*), the *premium* for COBRA continuation coverage may be up to 150% of the applicable *premium* for the additional months. Qualified beneficiaries who do not take the additional 11 months of special coverage will pay up to 102% of the *premium* cost.

OTHER INFORMATION

Additional information regarding rights and obligations under the Plan and under federal law may be obtained by contacting the *COBRA Service Provider* or the *Plan Manager*.

It is important for the *covered person* or qualified *beneficiary* to keep the Plan Administrator, *COBRA Service Provider* and *Plan Manger* informed of any changes in marital status, or a change of address.

COBRA Continued

PLAN CONTACT INFORMATION

Ceridian COBRA Continuation Services
3201 34th Street South
St. Petersburg, FL 33711-3828
1-800-488-8757

Humana Insurance Company
Billing/Enrollment Department
101 E. Main Street
Louisville, KY 40201
Toll Free: 1-877-597-7474

THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

CONTINUATION OF BENEFITS

Effective October 13, 1994 federal law requires that health plans must offer to continue coverage for *employees* who are absent due to service in the uniformed services and/or their *dependents*. Coverage may continue for up to 18 or 24 months after the date the *employee* is first absent due to uniformed service.

ELIGIBILITY

An *employee* is eligible for continuation under USERRA if absent from employment because of voluntary or involuntary performance of duty in the Armed Forces, Army National Guard, Air National Guard, or the commissioned corps of the Public Health Service, or any other category of persons designated by the President of the United States of America in a time of war or national emergency. Duty includes absence for active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, and for the purpose of an examination to determine fitness for duty.

PREMIUM PAYMENT

If continuation of Plan coverage is elected under USERRA, the *employee* or *dependent* is responsible for payment of the applicable cost of coverage. If the *employee* is absent for less than 31 days, the cost will be the amount the *employee* would otherwise pay for coverage. For absences longer than 30 days, the cost may be up to 102% of the cost of coverage under the Plan. This includes the *employee's* share and any portion previously paid by the *employer*.

DURATION OF COVERAGE

Elected continuation coverage under USERRA will continue until the earlier of:

- 18 months beginning the first day of absence from employment due to service in the uniformed services for elections made prior to 12/10/04; or
- 24 months beginning the first day of absence from employment due to service in the uniformed services for elections beginning on or after 12/10/04; or
- The day after the *employee* fails to apply for or return to employment as required by USERRA, after completion of a period of service.

Under federal law, the period of coverage available under USERRA shall run concurrently with the COBRA period available to an *employee* and/or eligible *dependents*.

OTHER INFORMATION

Employees should contact their *employer* with any questions regarding coverage normally available during a military leave of absence or continuation coverage and notify the *employer* of any changes in marital status, or a change of address.

MEDICAL CONVERSION PRIVILEGE

If *your* medical coverage under the Plan terminates, medical conversion coverage is available without medical examination. The medical conversion coverage will provide lesser benefits than this Plan.

You are eligible to apply for medical conversion if *you* were covered under the Plan for at least 90 days and:

1. *Your* coverage ends because *your* employment terminated;

2. *You* are the covered *dependent* former *spouse* or a covered *dependent* child of an *employee* whose marriage ended due to legal annulment, dissolution or divorce;

3. *You* are the surviving *dependent spouse* or child, in the event of the *employee's* death, or at the end of any survivorship continuation provided in the Plan; or

4. *You* have been a covered *dependent* child but no longer meet the definition of *dependent* under the Plan.

You have 31 days after the date *your* coverage terminates to make conversion application to the *Plan Manager*, and pay the required *premium* for *your* individual or family coverage. The premium must be paid monthly, in advance. *You* may obtain application forms from the *Plan Manager*. The conversion coverage will be effective on the day after *your* group medical coverage ends, provided *you* enroll and pay the first *premium* within 31 days after the date *your* coverage terminates.

LIMITATIONS

This privilege does *not* apply when *your* group medical coverage terminates under the Plan and is replaced with other group medical coverage within 31 days of the termination of *your* coverage under the Plan.

If *you* had any *pre-existing condition* which could have been excluded under the Plan, it will be excluded under the medical conversion coverage. The medical benefits under the conversion coverage in the first year will not exceed the benefit limits which would have been paid under the Plan. The benefits may be reduced by the amount of benefits paid under the Plan after *your* coverage ended.

DUPLICATION OF COVERAGE

HIC will not issue individual medical conversion to *you* if HIC determines that *you* have other coverage that would result in overinsurance or duplication of benefits with the medical conversion plan. HIC determines overinsurance according to its standards. Individual medical conversion may not be offered to *you* if *you* are eligible for *Medicare*. Please contact *your employer* or HIC for additional information.

COORDINATION OF BENEFITS

BENEFITS SUBJECT TO THIS PROVISION

Benefits described in this Plan are coordinated with benefits provided by other plans under which *you* are also covered. This is to prevent duplication of coverage and a resulting increase in the cost of medical coverage.

For this purpose, a plan is one which covers medical or dental expenses and provides benefits or *services* by group, franchise or blanket insurance coverage. This includes group-type contracts not available to the general public, obtained and maintained only because of the *covered person's* membership in or connection with a particular organization or group, whether or not designated as franchise, blanket, or in some other fashion. Plan also includes any coverage provided through the following:

1. *Employer*, trustee, union, *employee* benefit, or other association; or

2. Governmental programs, programs mandated by state statute, or sponsored or provided by an educational institution.

This Coordination of Benefits provision does not apply to any individual policies or Blanket Student Accident Insurance provided by or through an educational institution. Allowable expense means any *eligible expense*, a portion of which is covered under one of the plans covering the person for whom *claim* is made. Each plan will determine what is an allowable expense according to the provisions of the respective plan. When a plan provides benefits in the form of *services* rather than cash payments, the reasonable cash value of each *service* rendered will be deemed to be both an allowable expense and a benefit paid.

EFFECT ON BENEFITS

One of the plans involved will pay benefits first. This is called the primary plan. All other plans are called secondary plans.

When this Plan is the secondary plan, the sum of the benefit payable will not exceed 100% of the allowable expenses incurred under the Plan and any other plans included under this provision.

ORDER OF BENEFIT DETERMINATION

In order to pay *claims*, it must be determined which plan is primary and which plan(s) are secondary. A plan will pay benefits first if it meets one of the following conditions:

1. The plan has no coordination of benefits provision;

2. The plan covers the person as an *employee*;

3. For a child who is covered under both parents' plans, the plan covering the parent whose birthday (month and day) occurs first in the *calendar year* pays before the plan covering the other parent. If the birthdates of both parents are the same, the Plan which has covered the person for the longer period of time will be determined the primary plan;

Coordination of Benefits Continued

If a plan other than this Plan does not include provision 3, then the gender rule will be followed to determine which plan is primary.

4. In the case of *dependent* children covered under the plans of divorced or separated parents, the following rules apply:

    a. The plan of a parent who has custody will pay the benefits first;

    b. The plan of a step-parent who has custody will pay benefits next;

    c. The plan of a parent who does not have custody will pay benefits next;

    d. The plan of a step-parent who does not have custody will pay benefits next.

There may be a court decree which gives one parent financial responsibility for the medical or dental expenses of the *dependent* children. If there is a court decree, the rules stated above will not apply if they conflict with the court decree. Instead, the plan of the parent with financial responsibility will pay benefits first.

5. If a person is laid off or is retired or is a *dependent* of such person, that plan covers after the plan covering such person as an active *employee* or *dependent* of such *employee*. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule will be ignored.

If the above rules do not apply or cannot be determined, then the plan that covered the person for the longest period of time will pay first.

COORDINATION OF BENEFITS WITH MEDICARE

In all cases, Coordination of Benefits with *Medicare* will conform to Federal Statutes and Regulations. In the case of *Medicare* each individual who is eligible for *Medicare* will be assumed to have full *Medicare* coverage (i.e. Part A hospital insurance and Part B voluntary medical insurance) whether or not the individual has enrolled for full coverage. *Your* benefits under the Plan will be coordinated to the extent benefits would otherwise have been paid under *Medicare* as allowed by Federal Statutes and Regulations.

RIGHT OF RECOVERY

The Plan reserves the right to recover benefit payments made for an allowable expense under the Plan in the amount which exceeds the maximum amount the Plan is required to pay under these provisions. This right of recovery applies to the Plan against:

1. Any person(s) to, for or with respect to whom, such payments were made; or

2. Any other insurance companies, or organizations which according to these provisions, owe benefits due for the same allowable expense under any other plan.

The Plan alone will determine against whom this right of recovery will be exercised.

REIMBURSEMENT/SUBROGATION

The *beneficiary* agrees that by accepting and in return for the payment of *covered expenses* by the Plan in accordance with the terms of this Plan:

1. The Plan shall be repaid the full amount of the *covered expenses* it pays from any amount received from others for the *bodily injuries* or losses which necessitated such *covered expenses*. Without limitation, "amounts received from others" specifically includes, but is not limited to, liability insurance, worker's compensation, uninsured motorists, underinsured motorists, "no-fault" and automobile med-pay payments.

2. The Plan's right to repayment is, and shall be, prior and superior to the right of any other person or entity, including the *beneficiary*.

3. The right to recover amounts from others for the injuries or losses which necessitate *covered expenses* is jointly owned by the Plan and the *beneficiary*. The Plan is subrogated to the *beneficiary's* rights to that extent. Regardless of who pursues those rights, the funds recovered shall be used to reimburse the Plan as prescribed above; the Plan has no obligation to pursue the rights for an amount greater than the amount that it has paid, or may pay in the future. The rights to which the Plan is subrogated are, and shall be, prior and superior to the rights of any other person or entity, including the *beneficiary*.

4. The *beneficiary* will cooperate with the Plan in any effort to recover from others for the *bodily injuries* and losses which necessitate *covered expense* payments by the Plan. The *beneficiary* will notify the Plan immediately of any *claim* asserted and any settlement entered into, and will do nothing at any time to prejudice the rights and interests of the Plan. Neither the Plan nor the *beneficiary* shall be entitled to costs or attorney fees from the other for the prosecution of the *claim*.

RIGHT TO COLLECT NEEDED INFORMATION

You must cooperate with the *Plan Manager* and when asked, assist the *Plan Manager* by:

- Authorizing the release of medical information including the names of all *providers* from whom *you* received medical attention;
- Obtaining medical information and/or records from any *provider* as requested by the *Plan Manager*;
- Providing information regarding the circumstances of *your sickness* or *bodily injury*;
- Providing information about other insurance coverage and benefits, including information related to any *bodily injury* or *sickness* for which another party may be liable to pay compensation or benefits; and
- Providing information the *Plan Manager* requests to administer the Plan.

Failure to provide the necessary information will result in denial of any pending or subsequent *claims*, pertaining to a *bodily injury* or *sickness* for which the information is sought, until the necessary information is satisfactorily provided.

Reimbursement/Subrogation Continued

DUTY TO COOPERATE IN GOOD FAITH

You are obliged to cooperate with the *Plan Manager* in order to protect the Plan's recovery rights. Cooperation includes promptly notifying the *Plan Manager* that *you* may have a *claim*, providing the *Plan Manager* relevant information, and signing and delivering such documents as the *Plan Manager* reasonably request to secure the Plan's recovery rights. *You* agree to obtain the Plan's consent before releasing any party from liability for payment of medical expenses. *You* agree to provide the *Plan Manager* with a copy of any summons, complaint or any other process serviced in any lawsuit in which *you* seek to recover compensation for *your bodily injury* or *sickness* and its treatment.

You will do whatever is necessary to enable the *Plan Manager* to enforce the Plan's recovery rights and will do nothing after loss to prejudice the Plan's recovery rights.

You agree that *you* will not attempt to avoid the Plan's recovery rights by designating all (or any disproportionate part) of any recovery as exclusively for pain and suffering.

Failure of the *covered person* to provide the *Plan Manager* such notice or cooperation, or any action by the *covered person* resulting in prejudice to the Plan's rights will be a material breach of this Plan and will result in the *covered person* being personally responsible to make repayment. In such an event, the Plan may deduct from any pending or subsequent *claim* made under this Plan any amounts the *covered person* owes the Plan until such time as cooperation is provided and the prejudice ceases.

REIMBURSEMENT/SUBROGATION EXCLUSIONS

1. *Sickness* or *bodily injury* for which medical payments/personal injury protection (PIP) coverage exists under any automobile, homeowner, marine, aviation, premise, or any other similar coverage, whether such coverage is in effect on a primary, secondary, or excess basis. This exclusion applies up to the available limit under the other coverage regardless of whether a *claim* is filed with the medical payments/PIP *carrier*. Whether medical payment or expense coverage is payable under another coverage is to be determined as if the coverages under this Plan did not exist;

2. Any *covered expenses* to the extent of any amount received from others for the *bodily injuries* or losses which necessitate such benefits. "Amounts received from others" specifically includes, without limitation, liability insurance, worker's compensation, uninsured motorists, underinsured motorists, "no-fault" and automobile med-pay payments;

GENERAL PROVISIONS

The following provisions are to protect *your* legal rights and the legal rights of the Plan.

CONTESTABILITY

The Plan has the right to contest the validity of *your* coverage under the Plan at any time.

RIGHT TO REQUEST OVERPAYMENTS

The Plan reserves the right to recover any payments made by the Plan that were:

1. Made in error; or

2. Made to *you* or any party on *your* behalf where the Plan determines the payment to *you* or any party is greater than the amount payable under this Plan.

The Plan has the right to recover against *you* if the Plan has paid *you* or any other party on *your* behalf.

TIME LIMIT ON CERTAIN DEFENSES

A *claim* will not be reduced or denied after two years from the *effective date* of the benefit because a disease or physical condition not excluded and causing the loss existed before the benefit *effective date*.

WORKERS' COMPENSATION NOT AFFECTED

The Plan is not issued in lieu of, nor does it affect any requirement for coverage by any Workers' Compensation or Occupational Disease Act or Law.

WORKERS' COMPENSATION

If benefits are paid by the Plan and the Plan determines *you* received Workers' Compensation for the same incident, the Plan has the right to recover as described under the Reimbursement/Subrogation provision. The Plan will exercise its right to recover against *you* even though:

1. The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;

2. No final determination is made that *bodily injury* or *sickness* was sustained in the course of or resulted from *your* employment;

3. The amount of Workers' Compensation due to medical or health care is not agreed upon or defined by *you* or the Workers' Compensation *carrier*;

4. The medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

You hereby agree that, in consideration for the coverage provided by the Plan, *you* will notify the *Plan Manager* of any Workers' Compensation *claim you* make, and that *you* agree to reimburse the Plan as described above.

MEDICAID

This Plan will not take into account the fact that an *employee* or *dependent* is eligible for medical assistance or Medicaid under state law with respect to enrollment, determining eligibility for benefits, or paying *claims*.

If payment for Medicaid benefits has been made under a state Medicaid plan for which payment would otherwise be due under this Plan, payment of benefits under this Plan will be made in accordance with a state law which provides that the state has acquired the rights with respect to a covered *employee* to the benefits payment.

CONSTRUCTION OF PLAN TERMS

The *Plan Manager* has the sole right to construe and prescribe the meaning, scope and application of each and all of the terms of the Plan, including, without limitation, the benefits provided thereunder, the obligations of the *beneficiary* and the recovery rights of the Plan; such construction and prescription by the *Plan Manager* shall be final and uncontestable.

PRIVACY OF PROTECTED HEALTH INFORMATION

In order for the Plan to operate, it may be necessary from time to time for health care professionals, the Plan Administrator, individuals who perform Plan-related functions under the auspices of the Plan Administrator, the *Plan Manager* and other service *providers* that have been engaged to assist the Plan in discharging its obligations with respect to delivery of benefits, to have access to what is referred to as *protected health information*.

A *covered person* will be deemed to have consented to use of *protected health information* about him or her by virtue of enrollment in the Plan. Any individual who may not have intended to provide this consent and who does not so consent must contact the Plan Administrator prior to filing any *claim* for Plan benefits, as coverage under the Plan is contingent upon consent.

Individually identifiable health information will only be used or disclosed for purposes of Plan operation or benefits delivery. In that regard, only the minimum necessary disclosure will be allowed. The Plan Administrator, *Plan Manager*, and other entities given access to *protected health information*, as permitted by applicable law, will safeguard *protected health information* to ensure that the information is not improperly disclosed.

Disclosure of *protected health information* is improper if it is not allowed by law or if it is made for any purpose other than Plan operation or benefits delivery. Disclosure for Plan purposes to persons authorized to receive *protected health information* may be proper, so long as the disclosure is allowed by law and appropriate under the circumstances. Improper disclosure includes disclosure to the *employer* for employment purposes, *employee* representatives, consultants, attorneys, relatives, etc. who have not executed appropriate agreements effective to authorize such disclosure.

The *Plan Manager* will afford access to *protected health information* in its possession only as necessary to discharge its obligations as a service *provider*, within the restrictions noted above. However, Plan records that include *protected health information* are the property of the Plan. Information received by the *Plan Manager* is information received on behalf of the Plan.

General Provisions Continued

The *Plan Manager* will afford access to *protected health information* as reasonably directed in writing by the Plan Administrator, which shall only be made with due regard for confidentiality. In that regard, the *Plan Manager* has been directed that disclosure of *protected health information* to be made to the person(s) identified by the Plan Administrator.

Individuals who have access to *protected health information* in connection with their performance of Plan-related functions under the auspices of the Plan Administrator will be trained in these privacy policies and relevant procedures prior to being granted any access to *protected health information*. The *Plan Manager* and other Plan service *providers* will be required to safeguard *protected health information* against improper disclosure through contractual arrangements.

In addition, *you* should know that the *employer* / Plan Sponsor may legally have access, on an as-needed basis, to limited health information for the purpose of determining Plan costs, contributions, Plan design, and whether Plan modifications are warranted. In addition, federal regulators such as the Department of Health and Human Services and the Department of Labor may legally require access to *protected health information* to police federal legal requirements about privacy.

Covered persons may have access to *protected health information* about them that is in the possession of the Plan, and they may make changes to correct errors. *Covered persons* are also entitled to an accounting of all disclosures that may be made by any person who acquires access to *protected health information* concerning them and uses it other than for Plan operation or benefits delivery. In this regard, please contact the Plan Administrator.

Covered persons are urged to contact the originating health care professional with respect to medical information that may have been acquired from them, as those items of information are relevant to medical care and treatment. And finally, *covered persons* may consent to disclosure of *protected health information*, as they please.

CLAIMS PROCEDURES

SUBMITTING A CLAIM

This section describes what a *covered person* (or his or her authorized representative) must do to file a *claim* for Plan benefits.

- A *claim* must be filed with the *Plan Manager* in writing and delivered to the *Plan Manager*, by mail, postage prepaid.

- *Claims* must be submitted to the *Plan Manager* at the address indicated in the documents describing the Plan or *claimant's* identification card. *Claims* will not be deemed submitted for purposes of these procedures unless and until received at the correct address.

- Also, *claims* submissions must be in a format acceptable to the *Plan Manager* and compliant with any applicable legal requirements. *Claims* that are not submitted in accordance with the requirements of applicable federal law respecting privacy of protected health information and/or electronic *claims* standards will not be accepted by the Plan.

- *Claims* submissions must be timely. *Claims* must be filed as soon as reasonably possible after they are incurred, and in no event later than 15 months after the date of loss, except if *you* were legally incapacitated. Plan benefits are only available for *claims* that are incurred by a *covered person* during the period that he or she is covered under the Plan.

- *Claims* submissions must be complete. They must contain, at a minimum:

    a. The name of the *covered person* who incurred the *covered expense*;
    b. The name and address of the health care *provider*;
    c. The diagnosis of the condition;
    d. The procedure or nature of the treatment;
    e. The date of and place where the procedure or treatment has been or will be provided;
    f. The amount billed and the amount of the *covered expense* not paid through coverage other than Plan coverage, as appropriate;
    g. Evidence that substantiates the nature, amount, and timeliness of each *covered expense* in a format that is acceptable according to industry standards and in compliance with applicable law.

A general request for an interpretation of Plan provisions will not be considered to be a *claim*. Requests of this type, such as a request for an interpretation of the eligibility provisions of the Plan, should be directed to the Plan Administrator.

Medical *claims*, medical correspondence should be mailed to:

Humana Claims Office
P.O. Box 14601
Lexington, Kentucky 40512-4601

MISCELLANEOUS MEDICAL CHARGES

If *you* accumulate bills for medical items *you* purchase or rent yourself, send them to the *Plan Manager* at least once every three months during the year (quarterly). The receipts must include the patient name, name of item, date item purchased or rented and name of the *provider* of *service*.

PROCEDURAL DEFECTS

If a *pre-service claim* submission is not made in accordance with the Plan's procedural requirements, the *Plan Manager* will notify the *claimant* of the procedural deficiency and how it may be cured no later than within five (5) days (or within 24 hours, in the case of an *urgent care claim*) following the failure. A *post-service claim* that is not submitted in accordance with these *claims* procedures will be returned to the submitter.

ASSIGNMENTS AND REPRESENTATIVES

A *covered person* may assign his or her right to receive Plan benefits to a health care *provider* only with the consent of the *Plan Manager*, in its sole discretion, except as may be required by applicable law. Assignments must be in writing. If a document is not sufficient to constitute an assignment, as determined by the *Plan Manager*, then the Plan will not consider an assignment to have been made. An assignment is not binding on the Plan until the *Plan Manager* receives and acknowledges in writing the original or copy of the assignment before payment of the benefit.

If benefits are assigned in accordance with the foregoing paragraph and a health care *provider* submits *claims* on behalf of a *covered person*, benefits will be paid to that health care *provider*.

In addition, a *covered person* may designate an authorized representative to act on his or her behalf in pursuing a benefit *claim* or appeal. The designation must be explicitly stated in writing and it must authorize disclosure of Protected Health Information with respect to the *claim* by the Plan, the *Plan Manager* and the authorized representative to one another. If a document is not sufficient to constitute a designation of an authorized representative, as determined by the *Plan Manager*, then the Plan will not consider a designation to have been made. An assignment of benefits does not constitute designation of an authorized representative.

- Any document designating an authorized representative must be submitted to the *Plan Manager* in advance, or at the time an authorized representative commences a course of action on behalf of a *claimant*. At the same time, the authorized representative should also provide notice of commencement of the action on behalf of the *claimant* to the *claimant*, which the *Plan Manager* may verify with the *claimant* prior to recognizing the authorized representative status.

- In any event, a health care *provider* with knowledge of a *claimant's* medical condition acting in connection with an *urgent care claim* will be recognized by the Plan as the *claimant's* authorized representative.

Covered persons should carefully consider whether to designate an authorized representative. An authorized representative may make decisions independent of the *covered person*, such as whether and how to appeal a *claim* denial.

Claims Procedures Continued

CLAIMS DECISIONS

After submission of a *claim* by a *claimant*, the *Plan Manager* will notify the *claimant* within a reasonable time, as follows:

PRE-SERVICE CLAIMS

The *Plan Manager* will notify the *claimant* of a favorable or *adverse determination* within a reasonable time appropriate to the medical circumstances, but no later than 15 days after receipt of the *claim* by the Plan.

However, this period may be extended by an additional 15 days, if the *Plan Manager* determines that the extension is necessary due to matters beyond the control of the Plan. The *Plan Manager* will notify the affected *claimant* of the extension before the end of the initial 15-day period, the circumstances requiring the extension, and the date by which the Plan expects to make a decision.

If the reason for the extension is because of the *claimant's* failure to submit information necessary to decide the *claim*, the notice of extension will describe the required information. The *claimant* will have at least 45 days from the date the notice is received to provide the specified information.

URGENT CARE CLAIMS

The *Plan Manager* will determine whether a *claim* is an *urgent care claim*. This determination will be made on the basis of information furnished by or on behalf of a *claimant*. In making this determination, the *Plan Manager* will exercise its judgment, with deference to the judgment of a *physician* with knowledge of the *claimant's* condition. Accordingly, the *Plan Manager* may require a *claimant* to clarify the medical urgency and circumstances that support the *urgent care claim* for expedited decision-making.

The *Plan Manager* will notify the *claimant* of a favorable or *adverse determination* as soon as possible, taking into account the medical exigencies particular to the *claimant's* situation, but not later than 72 hours after receipt of the *urgent care claim* by the Plan.

However, if a *claim* is submitted that does not provide sufficient information to determine whether, or to what extent, expenses are covered or payable under the Plan, notice will be provided by the *Plan Manager* as soon as possible, but not more than 24 hours after receipt of the *urgent care claim* by the Plan. The notice will describe the specific information necessary to complete the *claim*.

- The *claimant* will have a reasonable amount of time, taking into account his or her circumstances, to provide the necessary information but not less than 48 hours.

- The *Plan Manager* will notify the *claimant* of the Plan's *urgent care claim* determination as soon as possible, but in no event more than 48 hours after the earlier of:

    a. The Plan's receipt of the specified information; or

    b. The end of the period afforded the *claimant* to provide the specified additional information.

Claims Procedures Continued

CONCURRENT CARE DECISIONS

The *Plan Manager* will notify a *claimant* of a *concurrent care decision* that involves a reduction in or termination of benefits that have been pre-authorized. The *Plan Manager* will provide the notice sufficiently in advance of the reduction or termination to allow the *claimant* to appeal and obtain a determination on review of the *adverse determination* before the benefit is reduced or terminated.

A request by a *claimant* to extend a course of treatment beyond the period of time or number of treatments that is a *claim* involving *urgent care* will be decided by the *Plan Manager* as soon as possible, taking into account the medical exigencies. The *Plan Manager* will notify a *claimant* of the benefit determination, whether adverse or not within 24 hours after receipt of the *claim* by the Plan, provided that the *claim* is submitted to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

POST-SERVICE CLAIMS

The *Plan Manager* will notify the *claimant* of a favorable or *adverse determination* within a reasonable time, but not later than 30 days after receipt of the *claim* by the Plan.

However, this period may be extended by an additional 15 days, if the *Plan Manager* determines that the extension is necessary due to matters beyond the control of the Plan. The *Plan Manager* will notify the affected *claimant* of the extension before the end of the initial 30-day period, the circumstances requiring the extension, and the date by which the Plan expects to make a decision.

If the reason for the extension is because of the *claimant's* failure to submit information necessary to decide the *claim*, the notice of extension will describe the required information. The *claimant* will have at least 45 days from the date the notice is received to provide the specified information. The *Plan Manager* will make a decision no later than 15 days after the earlier of the date on which the information provided by the *claimant* is received by the Plan or the expiration of the time allowed for submission of the additional information.

TIMES FOR DECISIONS

The periods of time for *claims* decisions presented above begin when a *claim* is received by the Plan, in accordance with these *claims* procedures.

PAYMENT OF CLAIMS

Many health care *providers* will request an assignment of benefits as a matter of convenience to both *provider* and patient. Also as a matter of convenience, the *Plan Manager* will, in its sole discretion, assume that an assignment of benefits has been made to certain Network *Providers*. In those instances, the *Plan Manager* will make direct payment to the *hospital*, clinic, or *physician's* office, unless the *Plan Manager* is advised in writing that *you* have already paid the bill. If *you* have paid the bill, please indicate on the original statement, "paid by *employee*," and send it directly to the *Plan Manager*. *You* will receive a written explanation of the benefit determination. The *Plan Manager* reserves the right to request any information required to determine benefits or process a *claim*. *You* or the *provider* of *services* will be contacted if additional information is needed to process *your claim*.

Claims Procedures Continued

When an *employee's* child is subject to a medical child support order, the *Plan Manager* will make reimbursement of *eligible expenses* paid by *you*, the child, the child's non-*employee* custodial parent, or legal guardian, to that child or the child's custodial parent, or legal guardian, or as provided in the medical child support order.

Payment of benefits under this Plan will be made in accordance with an assignment of rights for *you* and *your dependents* as required under state Medicaid law.

Benefits payable on behalf of *you* or *your* covered *dependent* after death will be paid, at the Plan's option, to any *family member(s)* or *your* estate. The *Plan Manager* will rely upon an affidavit to determine benefit payment, unless it receives written notice of valid *claim* before payment is made. The affidavit will release the Plan from further liability.

Any payment made by the *Plan Manager* in good faith will fully discharge it to the extent of such payment.

Payments due under the Plan will be paid upon receipt of written proof of loss.

INITIAL DENIAL NOTICES

Notice of a *claim* denial (including a partial denial) will be provided to *claimants* by mail, postage prepaid, by FAX, or by e-mail, as appropriate, within the time frames noted above.

However, notices of adverse decisions involving *urgent care claims* may be provided to a *claimant* orally within the time frames noted above for expedited *urgent care claim* decisions. If oral notice is given, written notification will be provided to the *claimant* no later than 3 days after the oral notification.

A *claims* denial notice will state the specific reason or reasons for the *adverse determination*, the specific Plan provisions on which the determination is based, and a description of the Plan's review procedures and associated timeline. The notice will also include a description of any additional material or information necessary for the *claimant* to perfect the *claim* and an explanation of why such material or information is necessary.

The notice will describe the Plan's review procedures and the time limits applicable to such procedures, including a statement of the *claimant's* right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

The notice will also disclose any internal Plan rule, protocol or similar criterion that was relied on to deny the *claim*. A copy of the rule, protocol or similar criterion relied upon will be provided to a *claimant* free of charge upon request.

If the *adverse determination* is based on *medical necessity, experimental, investigational or for research purposes*, or similar exclusion or limit, the notice will provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the *claimant's* medical circumstances, or a statement that such explanation will be provided free of charge upon request.

In the case of an adverse decision of an *urgent care claim*, the notice will provide a description of the Plan's expedited review procedures applicable to such *claims*.

Claims Procedures Continued

APPEALS OF ADVERSE DETERMINATIONS

A *claimant* must appeal an *adverse determination* within 180 days after receiving written notice of the denial (or partial denial). An appeal may be made by a *claimant* by means of written application to the *Plan Manager*, in person, or by mail, postage prepaid, to:

Humana G& A
P.O. Box 14546
Lexington, Kentucky 40512-4546

However, a *claimant* on appeal may request an expedited appeal of an adverse *urgent care claim* decision orally or in writing. In such case, all necessary information, including the Plan's benefit determination on review, will be transmitted between the Plan and the *claimant* by telephone, facsimile, or other available similarly expeditious method, to the extent permitted by applicable law.

Appeals of denied *claims* will be conducted promptly, will not defer to the initial determination, and will not be made by the person that made the initial adverse *claim* determination or a subordinate of that person. The determination will take into account all comments, documents, records, and other information submitted by the *claimant* relating to the *claim*.

A *claimant* may review relevant documents free of charge, and may submit issues and comments in writing. In addition, a *claimant* on appeal may, upon request, discover the identity of medical, or vocational experts whose advice was obtained on behalf of the Plan in connection with the *adverse determination* being appealed, as permitted under applicable law.

If the *claims* denial being appealed was based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is *experimental, investigational or for research purposes* or not *medically necessary*, or appropriate, the person deciding the appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The consulting health care professional will not be the same person who decided the initial appeal or a subordinate of that person.

TIME PERIOD FOR DECISIONS ON APPEAL

Appeals of *claims* denials will be decided and notice of the decision provided as follows:

Urgent Care Claims	As soon as possible, but not later than 72 hours after the *Plan Manager* has received the appeal request. (If oral notification is given, written notification will follow in hard copy or electronic format within the next three days.)
Pre-Service Claims	Within a reasonable period, but not later than 30 days after the *Plan Manager* has received the appeal request.
Post-Service Claims	Within a reasonable period, but not later than 60 days after the *Plan Manager* has received the appeal request.
Concurrent Care Decisions	Within the time periods specified above, depending on the type of *claim* involved.

APPEAL DENIAL NOTICES

Notice of a benefit determination on appeal will be provided to *claimants* by mail, postage prepaid, by FAX, or by e-mail, as appropriate, within the time frames noted above.

A notice that a *claim* appeal has been denied will state the specific reason or reasons for the *adverse determination* and the specific Plan provisions on which the determination is based.

The notice will also disclose any internal Plan rule, protocol or similar criterion that was relied on to deny the *claim* on appeal. A copy of the rule, protocol or similar criterion relied upon will be provided to a *claimant* free of charge upon request.

If the *adverse determination* is based on *medical necessity, experimental, investigational or for research purposes* or similar exclusion or limit, the notice will provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the *claimant's* medical circumstances, or a statement that such explanation will be provided free of charge upon request.

In the event of a denial of an appealed *claim*, the *claimant* on appeal will be entitled to receive upon request and without charge, reasonable access to and copies of any document, record or other information:

1. Relied on in making the determination;

2. Submitted, considered or generated in the course of making the benefit determination;

3. That demonstrates compliance with the administrative processes and safeguards required with respect to such determinations;

4. That constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment without regard to whether the statement was relied on.

RIGHT TO REQUIRE MEDICAL EXAMS

(Applies only to medical Plans)

The Plan has the right to require that a medical exam be performed on any *claimant* for whom a *claim* is pending as often as may be reasonably required. If the Plan requires a medical exam, it will be performed at the Plan's expense. The Plan also has a right to request an autopsy in the case of death, if state law so allow.

EXHAUSTION

Upon completion of the appeals process under this section, a *claimant* will have exhausted his or her administrative remedies under the Plan. If the *Plan Manager* fails to complete a *claim* determination or appeal within the time limits set forth above, the *claimant* may treat the *claim* or appeal as having been denied, and the *claimant* may proceed to the next level in the review process. After exhaustion, a *claimant* may pursue any other legal remedies available to him or her. Additional information may be available from a local U.S. Department of Labor Office.

LEGAL ACTIONS AND LIMITATIONS

No action at law or inequity may be brought with respect to Plan benefits until all remedies under the Plan have been exhausted and then prior to the expiration of the applicable limitations period under applicable law.

QUALITY IMPROVEMENT

The *Plan Manager* has a Quality Improvement program that reviews complaints and grievances concerning *provider* services and administration. This program identifies standards, reviews *services* to see that those standards are met, and recommends steps for improvement. If *you* have questions about the Humana Quality Improvement program, don't hesitate to contact us. *You* can request a program summary of Humana's progress toward meeting quality goals by calling customer service at 1-877-KYSPIRIT (1-877-597-7474).

DEFINITIONS

Accidental Injury (or Accidentally injured) means a sudden or unforeseen result of an external agent or trauma, independent of illness, which causes injury, including complications arising from that injury, to the body, and which is definite as to time and place.

Active status means performing on a regular, full-time basis all customary occupational duties, as determined by the *employer*, at the *employer's* business locations or when required to travel for the *employer's* business purposes. Each day of a regular paid vacation and any regular non-working holiday will be deemed *active status* if *you* were in an *active status* on *your* last regular working day prior to the vacation or holiday.

Adverse determination means a determination by the *Plan Manager* that the health care services furnished or proposed to be furnished to *you* are not *medically necessary* or are *experimental or investigational*; therefore, benefit coverage is denied, reduced or terminated.

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

Ambulatory surgical center means a *provider* with an organized staff of *physicians* which:

1. Has permanent facilities and equipment for the primary purpose of performing surgical and/or medical procedures to an *outpatient*;
2. Provides treatment by or under the supervision of *physicians* and nursing *services* whenever the patient is in the facility; and
3. Does not provide accommodations to *inpatients*.

Autism means a condition affecting a *covered person* ages two (2) through twenty-one (21) years of age, which includes:

(A) A total of six (6) or more items from subparagraphs 1, 2, and 3 of this paragraph, with at least two (2) from subparagraph 1 and one (1) each from subparagraphs 2 and 3:
   1. Qualitative impairment in social interaction, as manifested by at least two (2) of the following:
      a. Marked impairment in the use of multiple nonverbal behavior such as eye-to-eye gaze, facial express, body postures, and gestures to regulate social interaction;
      b. Failure to develop peer relationships appropriate to developmental level;
      c. A lack of spontaneous seeking to share enjoyment, interests or achievement with other people; or
      d. Lack of social or emotional reciprocity.
   2. Qualitative impairments in communications as manifested by at least one (1) of the following:
      a. Delay in, or total lack of, the development of spoken language;
      b. In individuals with adequate speech, marked impairment in the ability to imitate or sustain a conversation with others;
      c. Stereotyped and repetitive use of language or idiosyncratic language; or
      d. Lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental levels.
   3. Restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one (1) of the following:
      a. Encompassing preoccupation with one (1) or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus;
      b. Apparently inflexible adherence to specific, nonfunctional routines or rituals;

Definition Continued

c. Stereotyped and repetitive motor mannerisms; or
d. Persistent preoccupation with parts or objects.

(B) Delays or abnormal functioning in at least one (1) of the following areas, with onset prior to age three (3) years;
1. Social interaction;
2. Language as used in social communication; or
3. Symbolic or imaginative play; and

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

Balance billing means when *you* or *your* covered *dependents* use a *Non-PAR provider,* the *Plan Manager's* reimbursement will be payable on a *maximum allowable fee* basis. Any amounts above the *maximum allowable fee* will be the *members* responsibility and will NOT apply to the *out-of-pocket limit*.

Beneficiary means *you* and *your* covered *dependent(s),* or legal representative of either, and anyone to whom the rights of *you* or *your* covered *dependent(s)* may pass.

Benefit reductions means the amount by which payment for *covered services* will be reduced if the *covered person* fails to comply with the *plan delivery system rules*.

Bodily injury means injury due directly to an accident and independent of all other causes.

Calendar year means a period of time beginning on January 1 and ending on December 31.

Capitation fee means the fixed monthly fee paid to designated *provider*s for specified *covered services*. This fee is included in the monthly *premium* rates.

Case management means the process of assessing whether an alternative plan of care would more effectively provide *medically necessary* health care *services* in an appropriate setting.

Certified surgical assistant means a *certified surgical assistant* or certified first assistant who is certified by the National Surgical Assistant Association on the Certification of Surgical Assistants, the Liaison Council on Certification of Surgical Technologists, or the American Board of Surgical Assistants. The *certified surgical assistant* is an unlicensed health care *provider* who is directly accountable to a *physician* licensed pursuant to the provisions of KRS 311 or, in the absence of a *physician*, to a registered nurse licensed pursuant to the provisions of KRS Chapter 314.

Claim means a request by a *covered person* for payment of a benefit under the plan, including *hospital*, medical/surgical, and mental health/*substance abuse services*, prescription drugs, and other *services* and supplies.

Claimant means a *covered person* (or authorized representative) who files a *claim*.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1986, as amended, including parallel provisions as outlined in Title XXII of the Public Health Service Act.

Definition Continued

COBRA Service Provider means a *provider* of COBRA administrative services retained by the *Plan Manager* to provide specific COBRA administrative services.

Coinsurance means the percentage of an *eligible expense* that must be paid by the *covered person*. *Coinsurance* does not include *deductibles*, *copayments*, or non-*covered expense*s incurred during the *plan year*.

Complications of pregnancy means:

1. Conditions whose diagnoses are distinct from pregnancy but adversely affected by pregnancy or caused by pregnancy. Such conditions include: acute nephritis, nephrosis, cardiac decompensation, hyperemesis gravidarum, puerperal infection, toxemia, eclampsia and missed abortion;

2. A nonelective cesarean section surgical procedure;

3. Terminated ectopic pregnancy; or

4. Spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.

Complications of pregnancy does not mean:

1. False labor;

2. Occasional spotting;

3. Prescribed rest during the period of pregnancy;

4. Conditions associated with the management of a difficult pregnancy but which do not constitute distinct *complications of pregnancy*; or

5. An elective cesarean section.

Concurrent care decision means a decision by the Plan to reduce or terminate benefits otherwise payable for a course of treatment that has been approved by the Plan (other than by Plan amendment or termination) or a decision with respect to a request by a *claimant* to extend a course of treatment beyond the period of time or number of treatments that has been approved by the Plan.

Concurrent review means the process of assessing the continuing *medical necessity*, appropriateness, or utility of additional days of *hospital confinement*, *outpatient* care, and other health care *services*.

Confinement means being a resident patient in a *hospital* or a *qualified treatment facility* for at least 15 consecutive hours per day. Successive *confinements* are considered one *confinement* if:

1. Due to the same *bodily injury* or *sickness*; and

2. Separated by fewer than 30 consecutive days when *you* are not confined.

Definition Continued

Contract means the agreement between the Commonwealth and the *carrier* consisting of the RFP and any addenda, the *carrier's* proposal and any addenda acceptable to the Commonwealth, any written questions and answers drafted to clarify the proposal, any written master policy between the parties, including the *Summary Plan Description*, and the Division of Purchases MARS document.

Contract year means the year commencing on January 1 and ending on December 31 of each year. For the purposes of this RFP, the terms "*contract year*" and "*plan year*" are interchangeable.

Copayment means a specified amount the *covered person* must pay at the time *services* are rendered for certain *covered services*, which may not be used as part of the *deductible*.

Cosmetic surgery means *surgery* performed to reshape structures of the body in order to change *your* appearance or improve self-esteem.

Couple coverage means coverage for the *member* and his/her eligible covered *spouse*.

Coverage denial means the *Plan Manager* determined that a service, treatment, drug, or device is specifically limited or excluded under *your* Plan.

Coverage level means coverage for the *member* and his/her eligible covered *spouse*.

Covered expense (or Covered services) means *services* incurred by *you* or *your* covered *dependents* due to *bodily injury* or *sickness* for which benefits may be available under the Plan. *Covered expenses* are subject to all provisions of the Plan, including the limitations and exclusions. A charge for a *covered expense* shall be considered to have been incurred on the date the service or supply was provided.

Covered person means the *member* (*employee, retiree,* COBRA participant) and his/her covered *dependents*.

Creditable coverage means the total time of prior continuous health plan coverage periods used to reduce the length of any *pre-existing condition* limitation period applicable to *you* or *your dependents* under this Plan where these prior continuous health coverage(s) existed with no more than a 63-consecutive day lapse in coverage.

Prior coverage by a *covered person* under any of the following:

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

Definition Continued

Creditable coverage does not include any of the following:

1. accident-only coverage, disability income insurance, or any combination thereof;
2. supplemental coverage to liability insurance;
3. liability insurance, including general liability insurance and automobile liability insurance;
4. workers' compensation or similar insurance;
5. automobile medical payment insurance;
6. credit-only insurance;
7. coverage for on-site medical clinics;
8. benefits if offered separately:
    a. limited scope dental and vision;
    b. long-term care, nursing home care, home health care, community based care, or any combination thereof; and
    c. other similar, limited benefits.
9. benefits if offered as independent, non-coordinated benefits:
    a. specified disease or illness coverage; and
    b. hospital indemnity or other fixed indemnity insurance.
10. benefits if offered as a separate policy:
    a. Medicare Supplement insurance;
    b. supplemental coverage to the health plan for active and certain former military personnel, including TRICARE; and
    c. similar supplemental coverage provided to group health plan coverage.

Custodial care means *services* provided to assist in the activities of daily living which are not likely to improve *your* condition. Examples include, but are not limited to, assistance with dressing, bathing, toileting, transferring, eating, walking and taking medication. These *services* are considered *custodial care* regardless if a *qualified practitioner* or *provider* has prescribed, recommended or performed the *services*.

Dental injury is an injury caused by a sudden, violent, and external force that could not be predicted in advance and could not be avoided. *Dental injury* does not include chewing injuries.

Deductible means a specified dollar amount of *covered services* that must be incurred by the *covered person* before the plan shall provide benefits for all or part of the remaining *covered services* during the *plan year*.

Dependent means a covered *employee's*:

1. Legally recognized *spouse*;

2. Unmarried natural blood related child, step-child, legally adopted child or child for which the *employee* has legal guardianship whose age is less than the limiting age. Each child must legally qualify as a *dependent* as defined by the United States Internal Revenue Service.

   The limiting age for each *dependent* child is to the end of the year of his/her 23rd birthday. The *dependent* must resides with the *employee* in a parent-child relationship and who is *dependent* on the *employee* for more than 50% of his/her support and maintenance.

Definition Continued

Qualifying Relative: defined as the *member's* unmarried child(ren) including foster child(ren), grandchild(ren) or step-child(ren), who: (1) has the same principal abode as the *member* and is a *member* of the *member's* household; (2) has income less than $3,200 for the 2005 tax year; (3) received over half of his/her support from the *member* during the *calendar year* in which the *member's* taxable year begins; and (4) is not any other person's qualifying child.

A child will not qualify as a *member's* qualifying *dependent* or qualifying relative in three instances: (1) if a *member* is the *dependent* of a taxpayer, then the *member* may not have a qualifying child or relative, (2) if a child files a joint return with his/her *spouse*, then that individual cannot be a *dependent* of another person, or (3) the child is not a citizen or resident of the United States or a resident of Canada or Mexico.

Adopted children and children placed for adoption are subject to all terms and provisions of the Plan, with the exception of the *pre-existing condition* limitation.

3. A covered *employee's* child whose age is less than the limiting age and is entitled to coverage under the provisions of this Plan because of a medical child support order.

You must furnish satisfactory proof to the *Plan Manager* upon request that the above conditions continuously exist. If satisfactory proof is not submitted to the *Plan Manager*, the child's coverage will not continue beyond the last date of eligibility.

Dependents may only be covered under one state-sponsored plan. Unless both *employees* agree in writing, the *employee* with custody shall have first option to cover the *dependent* children.

A covered *dependent* child who attains the limiting age while covered under the Plan will remain eligible for benefits if all of the following exist at the same time:

1. Mentally retarded or permanently physically handicapped;

2. Incapable of self-sustaining employment;

3. The child meets all of the qualifications of a *dependent* as determined by the United States Internal Revenue Service;

4. Declared on and legally qualify as a *dependent* on the *employee's* federal personal income tax return filed for each year of coverage; and

5. Unmarried.

You must furnish satisfactory proof to the *Plan Manager* that the above conditions continuously exist on and after the date the limiting age is reached. The *Plan Manager* may not request such proof more often than annually after two years from the date the first proof was furnished. If satisfactory proof is not submitted to the *Plan Manager*, the child's coverage will not continue beyond the last date of eligibility.

Definition Continued

Diagnostic Admission means an admission of an *inpatient* that does not require the constant availability of medical supervision or *skilled nursing care* to monitor a condition. The primary purpose of such admission is to arrive at a diagnosis through the use of x-ray and laboratory tests, consultations, and evaluation, as documented by the *hospital's* medical records, these *diagnostic services* could be provided on an *outpatient* basis to determine the need for treatment.

Diagnostic Service means a test or procedure rendered because of specific symptoms and which is directed toward the determination of a definite condition or disease. A *diagnostic service* must be ordered by a *physician* or other professional *provider*.

Disease Management Program means a coordinated system of preventive, diagnostic, and therapeutic measures intended to provide cost-effective, quality healthcare for a patient population who have or are at risk for a specific chronic illness or medical condition.

Durable medical equipment (DME) means equipment that is *medically necessary* and able to withstand repeated use. It must also be primarily and customarily used to serve a medical purpose and not be generally useful to a person except for the treatment of a *bodily injury* or *sickness*.

Effective date means the date on which coverage for a *covered person* begins.

Eligible person means a person who meets the eligibility requirements of the *Kentucky Employees Health Plan*.

Eligible Expense means a *provider's* fee which:

1. is the *provider's* usual charge for a given service under the *covered person's* plan;
2. is within the range of fees charged by *providers* of similar training and experience for the same or similar service or supply within the same or similar limited geographic area; and
3. does not exceed the fee schedule developed by the *carrier* for a network *provider*.

The terms "*eligible expense*" and "reasonable and customary charge" are interchangeable.

Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain that a prudent lay person would reasonably have cause to believe constitutes a condition that the absence of immediate medical attention could reasonably be expected to result in: (a) placing the health or the individual or with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.

With respect to a pregnant woman who is having contractions: (a) a situation in which there is inadequate time to effect a safe transfer to another *hospital* before delivery; or (b) a situation in which transfer may pose a threat to the health or safety of the woman or the unborn child.

Employee means a person who is employed by agencies participating in the *Kentucky Employees Health Plan* and eligible to apply for coverage under a *Kentucky Employees Health Plan* or who is a retiree of a state sponsored Retirement System Health Plan.

Employer means the sponsor of the Group Plan or any subsidiary(s).

Definition Continued

Enrollment date means the first (1st) day of coverage of a *member* and his/her eligible *dependents* under the *certificate*, or, if there is a *waiting period*, the first day of the *waiting period* (typically the date employment begins).

Expense incurred means the fee charged for *services* provided to *you*. The date a *service* is provided is the *expense incurred* date.

***Experimental, investigational or for research purposes*:**
Services, supplies, or other care, including treatments, procedures, hospitalizations, drugs, biological products or medical devices, which a Peer Review Panel determines are:

1. not of proven benefit for the particular diagnosis or treatment of the *covered person's* particular condition;
2. not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of the *covered person's* particular condition; or
3. provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the United States Food and Drug Administration (FDA), the plan shall not cover any *services* or supplies, including treatment, procedures, drugs, biological products or medical devices or any hospitalization in connection with *experimental or investigational services* or supplies. The plan shall not cover any technology or any hospitalization in connection with such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of the *covered person's* particular condition. Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of the particular condition as explained below.

The *carrier* shall apply the following five (5) criteria in determining whether *services* or supplies are *experimental or investigational*:

1. Any medical device, drug, or biological product must have received final approval to market by the FDA for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug, or biological product for another diagnosis or condition shall require that one or more of the following established reference compendia: (1) the American Medical Association Drug Evaluations; (2) the American Hospital Formulary Service Drug Information; or (3) the United States Pharmacopoeia Drug Information, recognize the usage as appropriate medical treatment. As an alternative to such recognition in one (1) or more of the compendia, the usage of the drug shall be recognized as appropriate if it is recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal. A medical device, drug, or biological product that meets the above tests shall not be considered *experimental or investigational*. In any event, any drug which the FDA has determined to be contraindicated for the specific treatment for which the drug has been prescribed shall be considered *experimental or investigational*.

Definition Continued

2. Conclusive evidence from the published peer-review medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;
3. Demonstrated evidence as reflected in the published peer-review medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;
4. Proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and
5. Proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph C, are possible in standard conditions of medical practice, outside clinical investigatory settings.

Family coverage means coverage for the *member*, the *member's spouse* under an existing legal marriage, and one (1) or more *dependent* children.

Family maximum deductible means the total sum of *eligible expense*s applied toward the *deductible* for persons covered under a *member's* plan.

Family member means *you* or *your spouse*, or *you* or *your spouse's* child, brother, sister, parent, grandchild or grandparent.

Free-standing Renal Dialysis Facility means a *provider* other than a *hospital* which is primarily engaged in providing renal dialysis treatment, maintenance or training to *outpatients*.

Free-standing surgical facility means a public or private establishment licensed to perform *surgery* and which has permanent facilities that are equipped and operated primarily for the purpose of performing *surgery*. It does not provide *services* or accommodations for patients to stay overnight.

Hazardous duty retiree means a *retiree* in (a) any position whose principal duties involve active law enforcement, including the positions of probation and parole officer and Commonwealth detective, active fire suppression or prevention, or other positions, including, but not limited to, pilots of the Transportation Cabinet and paramedics and *Emergency* Medical Technicians, with duties that require frequent exposure to a high degree of danger or peril and also require a high degree of physical conditioning, and (b) positions in the Department of Corrections in state correctional institutions and the Kentucky Correctional Psychiatric Center with duties that regularly and routinely require face-to-face contact with inmates.

Hearing aids means any wearable, non-disposable instrument or device designed to aid or compensate for impaired human hearing and any parts, attachments, or accessories, including ear molds, excluding batteries and cords. In addition, *services* necessary to assess, select, and appropriately adjust or fit the *hearing aid* to ensure optimal performance.

Definition Continued

Home Health Agency means an agency that provides intermittent skilled nursing and health related *services* to patients in their homes under a treatment plan prescribed by a *physician*. The agency must be licensed as a *Home Health Agency* by the state in which it operates or be certified to participate in Medicare as a *Home Health Agency*.

Hospice means a *provider*, other than a facility that treats *inpatients*, which is primarily engaged in providing pain relief, symptom management, and supportive *services* to terminally ill persons and their families. The facility must be operated in accordance with the laws of the jurisdiction in which it is located.

Hospital means an institution which:

1. Maintains permanent full-time facilities for bed care of resident patients;

2. Has a *physician* and surgeon in regular attendance;

3. Provides continuous 24 hour a day nursing *services* by, or under the supervision of, registered nurses;

4. Is primarily engaged in providing diagnostic and therapeutic facilities for medical or surgical care of sick or injured persons under the supervision of a staff of fully licensed *physicians*. No *claim* for payment of treatment, care, or *services* shall be denied because a *hospital* lacks major surgical facilities and is primarily of a rehabilitative nature, if such rehabilitation is specifically for treatment of physical disability;

5. Is legally operated in the jurisdiction where located; and

6. Has surgical facilities on its premises or has a contractual agreement for surgical *services* with an institution having a valid license to provide such surgical *services*; or

7. It is a *hospital* accredited by the Joint Commission on the Accreditation of Healthcare Organizations, the American Osteopathic Association, or the Commission on the Accreditation of Rehabilitative Facilities, or certified by the Kentucky Division of Licensure and Regulation.

Hospital does not include an institution which is principally a rest home, skilled *nursing facility*, convalescent home or home for the aged. *Hospital* does not include a place principally for the treatment of alcoholism, chemical dependence or *mental disorders*.

Independent panel means a separate review agency responsible for Utilization/*Case Management* determination.

Inpatient means a *covered person* who is treated as a registered bed patient in a *hospital* or other institutional *provider* and for whom a room and board charge is made.

Kentucky Employees Health Plan means the group which is composed of eligible *employees* of state agencies, boards of education, local health departments, quasi agencies, the Kentucky Community and Technical College System, *retiree* (as defined in this Section) of the Kentucky Retirement Systems, Kentucky Teachers' Retirement System, the Legislators Retirement Plan, and the Judicial Retirement Plan, and their eligible *dependents*.

Definition Continued

Late applicant means an *employee* and/or an *employee's* eligible *dependent* who applies for medical coverage more than 30 days after the eligibility date. An individual shall not be considered a late enrollee if: (a) the person enrolls during his/her initial enrollment period; (b) the person enrolls during any annual open enrollment period; or (c) the person enrolls during a *Special Enrollment period*.

Maintenance care means any *service* or activity which seeks to prevent *bodily injury* or *sickness*, prolong life, promote health or prevent deterioration of a *covered person* who has reached the maximum level of improvement or whose condition is resolved or stable.

Maximum allowable fee for a *service* means the lesser of:

1. The fee most often charged in the geographical area where the *service* was performed;
2. The fee most often charged by the *provider*;
3. The fee which is recognized as reasonable by a prudent person;
4. The fee determined by comparing charges for similar *services* to a national data base adjusted to the geographical area where the *services* or procedures were performed; or
5. The fee determined by using a national relative value scale. Relative value scale means a methodology that values medical procedures and *services* relative to each other that includes, but is not limited to, a scale in terms of difficulty, work, risk, as well as the material and outside costs of providing the *service*, as adjusted to the geographic area where the *services* or procedures were performed.

Maximum benefit means the maximum amount that may be payable for each *covered person*, for *expense incurred*. The applicable *maximum benefit* is shown on the Schedule of Benefits. No further benefits are payable once the *maximum benefit* is reached.

Medically necessary or medical necessity means the extent of *services* required to diagnose or treat a *bodily injury* or *sickness* which is known to be safe and effective by the majority of *qualified practitioners* who are licensed to diagnose or treat that *bodily injury* or *sickness*. Such *services* must be:

1. Performed in the least costly setting required by *your* condition;
2. Not provided primarily for the convenience of the patient or the *qualified practitioner*;
3. Appropriate for and consistent with *your* symptoms or diagnosis of the *sickness* or *bodily injury* under treatment;
4. Furnished for an appropriate duration and frequency in accordance with accepted medical practices, and which are appropriate for *your* symptoms, diagnosis, *sickness* or *bodily injury*; and
5. Substantiated by the records and documentation maintained by the *provider* of *service*.

Medicare means Title XVIII, Parts A and B of the Social Security Act, as enacted or amended.

Definition Continued

Member means an *employee, Retiree,* or COBRA participant who is covered by one (1) of the health plans offered by the *Kentucky Employees Health Plan*.

Mental disorder means a mental, nervous, or emotional disease or disorder of any type as classified in the Diagnostic and Statistical Manual of *Mental Disorders*, regardless of the cause or causes of the disease or disorder.

Mental health condition means a condition that manifests symptoms, which are primarily mental or nervous, regardless of any underlying physical cause. A *mental health condition* includes, but is not limited to, psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders e.g., attention deficit disorder, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

In determining whether or not a particular condition is a *mental health condition*, the *carrier* may refer to the current edition of the Diagnostic and Statistical Manual of Mental Conditions (DSM) of the American Psychiatric Association, or the International Classification of Diseases (ICD) manual.

Morbid obesity means morbid or clinically severe obesity correlated with a Body Mass Index (BMI) of 40 kg/m2 or with being 100 pounds over ideal body weight.

Non-PAR provider means any *provider* other than a *PAR provider*.

Nursing Facility means a *provider*, which is primarily engaged in providing skilled, nursing care and related *services* to an *inpatient* requiring convalescent and rehabilitative care. Such care must be rendered by or under the supervision of a *physician* and eligibility for payment is based on care rendered in compliance with Medicare-established guidelines. The facility must be operated in accordance with the laws of the jurisdiction in which it is located. A *nursing facility* is not, other than incidentally, a place that provides: (a) minimal care, *custodial care*, ambulatory care, or part-time care *services*; and (b) Care or treatment of *mental health condition*s, alcoholism, drug abuse, or pulmonary tuberculosis.

Out-of-Pocket Limit means a specified amount of *expense incurred* by a *covered person* for *covered services* in a *plan year* that exceeds the maximum amount of out-of-pocket expenditures as specified on the schedule of benefits. Any *deductible* amount, where applicable, will be included in the out-of-pocket maximum. When the *out-of-pocket limit* is reached, *coinsurance* ceases for those *covered services* specified in the schedule of benefits. It does not include any amounts not paid because a *maximum benefit* limit has been reached, co-payments, or any amount above an *eligible expense*.

Outpatient means a *covered person* who receives *services* or supplies while not an *inpatient*.

Parent Plus Coverage means coverage for the *member* and eligible *dependent*s except the *spouse*.

PAR provider means any *provider* who has an agreement with the *carrier* or the *carrier's* associated medical groups to *provider covered expenses.*

Definition Continued

Physician means any Doctor of Medicine or Doctor of Osteopathy who is licensed and legally entitled to practice medicine, perform *surgery*, and dispense drugs.

Physician assistant means a person who has graduated from a *physician* assistant or surgeon assistant program accredited by the American Medical Association's Committee on Allied Health Education and Accreditation or the Commission on Accreditation of Allied Health Education Programs and who has passed the certifying examination administered by the National Commission on Certification of *Physician* Assistants or who possesses a current *physician* assistant *certificate* issued by the board prior to July 15, 1998.

Plan means the health care plan or plans sponsored and maintained by the *Commonwealth Group* with respect to which benefits are provided to *covered persons* under this *certificate*.

Plan Delivery System Rules means the specific procedures and/or terminology established by a *carrier* that must be followed to obtain *maximum benefits* for *covered services* under the plan.

Plan Manager means Humana Insurance Company (HIC). The *Plan Manager* provides *services* to the Plan Administrator, as defined under the *Plan Manager* Agreement. The *Plan Manager* is not the Plan Administrator or the Plan Sponsor.

Plan year means a period of time beginning on the Plan anniversary date of any year and ending on the day before the same date of the succeeding year.

Post-service claim means any *claim* for a benefit under a group health plan that is not a *pre-service claim*.

Preadmission testing means only those *outpatient* x-ray and laboratory tests made within seven days before admission as a registered bed patient in a *hospital*. The tests must be for the same *bodily injury* or *sickness* causing the patient to be *hospital* confined. The tests must be accepted by the *hospital* in lieu of like tests made during *confinement*. *Preadmission testing* does not mean tests for a routine physical check-up.

Precertification means the process of assessing the *medical necessity*, appropriateness, or utility of proposed non-*emergency hospital* admissions, surgical procedures, *outpatient* care, and other health care *services*.

Predetermination of benefits means a review by the *Plan Manager* of a *qualified practitioner's* treatment plan, specific diagnostic and procedure codes and expected charges prior to the rendering of *services***.**

Pre-existing condition means a physical or mental condition for which *you* have received medical attention (medical attention includes, but is not limited to: *services* or care) during the six month period immediately prior to the *enrollment date* of *your* medical coverage under the Plan. *Pre-existing conditions* are covered after the end of a period of twelve months after the *enrollment date* (first day of coverage or, if there is a *waiting period*, the first day of the *waiting period*).

Pre-existing condition limitations will be waived or reduced for *pre-existing conditions* that were satisfied under previous *creditable coverage*.

Definition Continued

Premium means the periodic charges due which the *member*, or the *member's* group, must pay to maintain coverage.

Premium Due Date means the date on which a *premium* is due to maintain coverage under this *certificate*.

Pre-service claim means a *claim* with respect to which the terms of the Plan condition receipt of a Plan benefit, in whole or in part, on approval of the benefit by the *Plan Manager* in advance of obtaining medical care.

Primary Care Physician means a network *provider* who is a practitioner specializing in family practice, general practice, internal medicine, or pediatrics who supervises, coordinates and provides initial care and basic medical *services* to a *covered person*, initiates the *covered person's* referral for specialist *services*, and is responsible for maintaining continuity of patient care.

Protected health information means individually identifiable health information about a *covered person*, including: (a) patient records, which includes but is not limited to all health records, *physician* and *provider* notes and bills and *claims* with respect to a *covered person*; (b) patient information, which includes patient records and all written and oral information received about a *covered person*; and (c) any other individually identifiable health information about *covered persons*.

Provider means a facility or person, including a *hospital* or *physician*, which is licensed, where required, to render *covered expenses*. *Providers* other than a *hospital* or *physician*, including a Doctor of Osteopathy, include, but not limited to:

Ambulatory Care Facility
Birthing Center
Certified Surgical Assistant
Freestanding Renal Dialysis Facility
Home Health Agency
Hospice
Psychiatric Facility
Nursing Facility
Substance Abuse Treatment Facility
Advanced Registered Nurse Practitioner
Doctor of Chiropractic
Doctor of Dental Medicine
Doctor of Dental *Surgery*
Doctor of Optometry
Doctor of Podiatry
Doctor of Surgical Chiropody
Licensed Psychologist
Licensed Psychological Associate
Licensed Psychological Practitioner
Licensed Clinical Social Worker
Licensed Physical Therapist
Licensed Practical Nurse
Licensed Speech Pathologist
Licensed Speech Therapist
Licensed Occupational Therapist
Licensed Pharmacist
Midwife
Registered Nurse
Registered Nurse First Assistant
Physician Assistant
Respiratory Therapist
Certified Psychologist
Certified Psychological Associate
Opthalmic Dispenser

Definition Continued

Psychiatric Facility means a *provider* primarily engaged in providing diagnostic and therapeutic *services* for the treatment of *mental health conditions*. The facility must be operated in accordance with the laws of the jurisdiction in which it is located and provide treatment by or under the care of *physicians* and nursing *services* whenever the patient is in the facility.

Qualified beneficiary means any individual who, on the day before a COBRA *qualifying event*, is covered under the plan by virtue of being on that day a *covered person*, or any child who is born or placed for adoption with a *member* during a period of COBRA continuation coverage.

Qualified practitioner means a practitioner, professionally licensed by the appropriate state agency to diagnose or treat a *bodily injury* or *sickness*, and who provides *services* within the scope of that license.

Qualified treatment facility means only a facility, institution or clinic duly licensed by the appropriate state agency, and is primarily established and operating within the scope of its license.

Qualifying event means a specific situation or occurrence that enables an *eligible person* to enroll or disenroll outside the designated enrollment period as a result of that person becoming eligible for or losing eligibility for coverage under this group plan or another group plan.

Registered Nurse First Assistant means a nurse who:

1. Holds a current active registered nurse licensure;
2. Is certified in perioperative nursing; and
3. Has successfully completed and holds a degree or certificate from a recognized program, which shall consist of: (a) the Association of Operating Room Nurses, Inc., Core Curriculum for the *registered nurse first assistant*; and (b) one (1) year of postbasic nursing study, which shall include at least forty-five (45) hours of didactic instruction and 140 hours of clinical internship or its equivalent of two (2) college semesters.

A registered nurse who was certified prior to 1995 by the Certification Board of Perioperative Nursing shall not be required to fulfill the requirements of paragraph (c) of this subsection.

Rehabilitation Center means a facility which provides *services* of non-acute rehabilitation. All *services* are provided under the direction of a psychiatrist, a medical doctor with a specialty in rehabilitation and physical medicine. The facility is staffed around the clock by registered nurses and it does not provide *services* of a custodial nature. The facility must be Medicare certified licensed by the State Department of Health as a "special *hospital*" and accredited by the Joint Commission on Accreditation of Healthcare Organizations. It is also accredited by the Commission on Accreditation of Rehabilitation Facilities.

Respite Care means care that is necessary to provide temporary relief from caregiving responsibilities, to support caregivers who are actively involved in providing the care required by a *covered person*, and whose continuing support is necessary to maintain the individual at home.

Retiree means a *covered person* of a retirement plan administered by the Kentucky Retirement Systems, Kentucky Teachers' Retirement System, Kentucky Legislators' Retirement Plan, Kentucky Judicial Retirement Plan or any other state sponsored retirement system, who is under age sixty-five (65) or is age 65 or older and is non Medicare eligible.

Definition Continued

Services mean procedures, surgeries, exams, consultations, advice, diagnosis, referrals, treatment, tests, supplies, drugs, devices or technologies.

Sickness means a disturbance in function or structure of *your* body which causes physical signs or symptoms and which, if left untreated, will result in a deterioration of the health state of the structure or system(s) of *your* body. The term also includes: (a) pregnancy; (b) any medical complications or pregnancy; and (c) a covered newborns congenital defects, metabolic diseases or birth abnormalities, including premature birth for which more than routine nursery care is required.

Single coverage means coverage for the *member* only.

Skilled Nursing Care means *services*, supplies, or other care needed for medical conditions that require treatment by skilled medical personnel such as registered nurses or professional therapists. Care must be available twenty-four (24) hours per day, be ordered by a *physician*, and usually involves a treatment plan designed specifically for each patient.

Sound natural tooth means a tooth that:

1. Is organic and formed by the natural development of the body (not manufactured);

2. Has not been extensively restored;

3. Has not become extensively decayed or involved in periodontal disease; and

4. Is not more susceptible to injury than a whole natural tooth.

Special enrollment period means a period of time during which an *eligible person* or *dependent* who loses other health insurance coverage or incurs a change in status may enroll in the plan without being considered a *late enrollee*.

Spouse means a person married to the *member* under an existing legal marriage.

Substance abuse means an illness resulting from alcoholism or the dependence, addiction or abuse of alcohol, chemicals, or drugs.

Substance Abuse Treatment Facility means a *provider* that is primarily engaged in providing detoxification and rehabilitation treatment for *substance abuse*. The facility must be operated and licensed in accordance with the laws of the jurisdiction in which it is located and provide treatment by or under the care of *physicians* and nursing *services* whenever the patient is in the facility.

Summary Plan Description (SPD) means the document which lists definitions, benefits, exclusions, and other provisions of coverage under the *Plan*.

Surgery means excision or incision of the skin or mucosal tissues, or insertion for exploratory purposes into a natural body opening. This includes insertion of instruments into any body opening, natural or otherwise, done for diagnostic or other therapeutic purposes.

Definition Continued

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

Therapy Service means *services*, supplies, or other care used for the treatment of a *sickness* or *bodily injury* to promote the recovery of the patient. *Therapy services* include, but are not limited to:

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

2. Respiratory Therapy – Introduction of dry or moist gases into the lungs for treatment purposes.

3. Speech Therapy – The treatment rendered to restore speech loss due to *sickness* or *bodily injury*.

4. Cardiac Rehabilitation – Treatment provided to individuals who have suffered a heart attack, have had heart *surgery*, or have other cardiac problems.

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

Timely applicant means an *employee* and/or an *employee's* eligible *dependent* who applies for medical coverage within 30 days of the eligibility date.

Total disability *or* ***totally disabled*** means:

1. During the first twelve months of disability *you* or *your* employed covered *spouse* are at all times prevented by *bodily injury* or *sickness* from performing each and every material duty of *your* respective job or occupation;

2. After the first twelve months, *total disability* or *totally disabled* means that *you* or *your* employed covered *spouse* are at all times prevented by *bodily injury* or *sickness* from engaging in any job or occupation for wage or profit for which *you* or *your* employed covered *spouse* are reasonably qualified by education, training or experience;

3. For a non-employed *spouse* or a child, *total disability* or *totally disabled* means the inability to perform the normal activities of a person of similar age and gender.

A *totally disabled* person also may not engage in any job or occupation for wage or profit.

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

Definition Continued

Urgent care claim means a *claim* for medical care or treatment with respect to which the application of the time periods for making non-*urgent care* determinations:

- Could seriously jeopardize the life or health of the *claimant* or the ability of the *claimant* to regain maximum function; or

- In the opinion of a *physician* with knowledge of the *claimant's* medical condition, would subject the *claimant* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *claim*.

- Generally, whether a *claim* is a *claim* involving *urgent care* will be determined by the *Plan Manager*. However, any *claim* that a *physician* with knowledge of a *claimant's* medical condition determines is a "*claim* involving *urgent care*" will be treated as a "*claim* involving *urgent care*."

Utilization review means the process of assessing the *medical necessity*, appropriateness, or utility of *hospital* admissions, surgical procedures, *outpatient* care, and other health care *services*. *Utilization review* includes *precertification* and *concurrent review*.

Waiting Period means the period of time before an individual becomes eligible for coverage under the *plan*.

Wellness Program means educational and clinical *services* designed to improve a *member's* health by promoting healthy behaviors, such as eating well, exercising, and assistance in altering unhealthy behaviors.

You and your means *you* as the *employee* and any of *your* covered *dependents*, unless otherwise indicated.

IMPORTANT NOTICE
FROM THE KENTUCKY EMPLOYEES HEALTH PLAN
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 the Kentucky Employees Health Plan (KEHP), and new prescription drug coverage available January 1, 2006 for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

1. **Starting January 1, 2006, new Medicare prescription drug coverage will be available to everyone with Medicare.**

2. **Pricewaterhouse Coopers (PwC) has determined that the prescription drug coverage offered by the Kentucky Employees Health Plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay.**

3. **Read this notice carefully - it explains the options you have under Medicare prescription drug coverage, and can help you decide whether or not you want to enroll.**

You may have heard about Medicare's new prescription drug coverage, and wondered how it would affect you. PwC has determined that your prescription drug coverage with the KEHP is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay.

Starting January 1, 2006, prescription drug coverage will be available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans will provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium.

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare coverage.

People with Medicare can enroll in a Medicare prescription drug plan from November 15, 2005 through May 15, 2006. However, because you have existing prescription drug coverage that, on average, is as good as Medicare coverage, you can choose to join a Medicare prescription drug plan later. Each year after that, you will have the opportunity to enroll in a Medicare prescription drug plan between November 15th through December 31st.

If you do decide to enroll in a Medicare prescription drug plan and drop your KEHP prescription drug coverage, be aware that you may not be able to get this coverage back.

If you drop your coverage with the KEHP and enroll in a Medicare prescription drug plan, you may not be able to get this coverage back later. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

In addition, your current coverage pays for other health expenses, in addition to prescription drugs, and you will still be eligible to receive all of you current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan.

You should also know that if you drop or lose your coverage with the KEHP and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more to enroll in Medicare prescription drug coverage later. If after May 15, 2006, you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage; your monthly premium will go up at least 1% per month for every month after May 15, 2006 that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare coverage. In addition, you may have to wait until next November to enroll.

For more information about this notice or your current prescription drug coverage…

Contact our office for further information at 888-581-8834. NOTE: You may receive this notice at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage…

More detailed information about Medicare plans that offer prescription drug coverage will be available in October 2005 in the "Medicare & You 2006" handbook. You'll get a copy of the handbook in the mail from Medicare. You may also be contacted directly by Medicare prescription drug plans. You can also get more information about Medicare prescription drug plans from these places:

- Visit www.medicare.gov for personalized help,
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number)
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage after May 15, 2006, you may need to give a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Date:	November 3, 2005
Name of Entity/Sender:	Department for Employee Insurance
Address:	200 Fair Oaks Lane Suite 501 Frankfort, KY 40601
Phone Number:	888-581-8834

EXHIBIT A

Event	*Accident or Health Plan Covering Expenses of Employee, Spouse, Eligible Dependents*
Change in Legal Marital Status	
Marriage	Add employee and/or spouse and/or dependents (1) (11) (12) *or* →→→ ---------- Drop employee/dependents if person becomes covered under spouse's plan (12) (10)
Divorce, legal separation, annulment	Add employee and dependents <u>if event causes loss of coverage under spouse's plan</u>, (1) (10) (11) (12) *or* ---------- Drop spouse; also drop family members added to former spouse's plan (12)
Spouse's death	Add employee and any dependent who loses coverage under spouse's plan, (1) (10) (11) (12) *or* ---------- Drop spouse (12)
Change in Number of Dependents	
Number of employee's eligible dependents increases by the following: birth; adoption (10); and placement for adoption (10)	Add employee and/or spouse and/or other dependents (1) (11) (12)
Number of employee's eligible dependents decreases (e.g., by death or because child becomes ineligible)	Drop affected dependent (12)
Change in Employee's Employment Status	
Employee terminates employment	Cease contributions
Employee is rehired less than 30-days after termination of employment.	Reinstate prior election unless intervening status change event * *Employee must request status change election within 30-days of rehire.
Employee is rehired more than 30-days after termination of employment	Make election to same extent permitted as new employee
Employee commences official leave without pay	Cease contributions
Employee returns from official leave without pay	Reinstate prior election unless intervening status change event (9)

Event	*Accident or Health Plan Covering Expenses of Employee, Spouse, Eligible Dependents*
Employee begins unpaid FMLA leave (4) or Military Leave ***NOTE: Employee may choose not to participate; otherwise they must choose one payment option or another**	Cease contributions *or* Prepayment: Employee may increase election to prepay coverage contributions for FMLA leave period *or* Pay-as-you-go: Employee may make contributions on the same schedule as payments would have been made otherwise *or* Catch-Up Option: If agreed to by both parties PRIOR to the FMLA leave, the employer may make contributions on behalf of the employee and may recoup the contributions upon the employee's return to employment
Employee returns from unpaid FMLA leave (4) or Military Leave	Reinstate prior election unless intervening status change event (9) NOTE: Employees returning from Military Leave are eligible for coverage immediately upon return or may delay the effective date until military coverage ends (employee's option)
Employee commences paid leave (assuming event does not affect eligibility for coverage)	No change
Employee returns from paid leave	No change
Employee changes worksite	No change

Event	*Accident or Health Plan Covering Expenses of Employee, Spouse, Eligible Dependents*
Other change in employee's employment status (e.g., switch from salaried to hourly status) that causes employee to cease eligibility under plan	Cease contributions
Other change in employee's employment status (e.g., switch from hourly to salaried status) that causes employee to become eligible for coverage under plan	Make elections as if a new employee, unless there was less than a 30-day break in employment.
Change in Spouse or Dependent Employment Status (Dependent must continue to meet all eligibility requirements.)	
Spouse or dependent terminates employment	Add employee, spouse, and dependents (1) if event adversely affects eligibility for coverage under spouse's or dependent's health plan (10) (11) (12)
Spouse or dependent commences employment	Drop employee, spouse, or dependent who becomes covered under spouse's or dependent's plan (12) (10)
Spouse or dependent is out of work due to strike or lockout	Add employee, spouse, and dependents (1) if event adversely affects eligibility for coverage under health plan of spouse or dependent (10) (11) (12)
Spouse or dependent returns to work following cessation of strike or lockout	Drop employee, spouse, or dependent who becomes covered under spouse's or dependent's health plan (12) (10)
Spouse or dependent commences unpaid leave (if the event adversely affects eligibility for coverage under the spouse or dependent's plan)	Add employee, spouse, and dependent (1) (10) (11) (12)
Spouse or dependent returns from unpaid leave	Drop employee, spouse, or dependent who becomes covered under spouse's or dependent's health plan (12) (10)
Other change in spouse's or dependent's employment status that causes spouse or dependent to cease to be eligible for coverage under spouse's or dependent's plan (e.g., switch from salaried to hourly status)	Add employee, spouse, and dependent (1) (10) (11) (12)
Other change in employment status that causes spouse or dependent to gain eligibility for coverage under spouse's or dependent's plan (e.g., switch from hourly to salaried status)	Drop coverage for employee, spouse, or dependent who becomes covered under spouse's or dependent's plan (10) (12)
Change in Dependent Eligibility	
Dependent ceases to satisfy plan eligibility requirements on account of age, marriage or any similar circumstance (support and maintenance)	Drop coverage for dependent (12)

Event	*Accident or Health Plan Covering Expenses of Employee, Spouse, Eligible Dependents*
Unmarried dependent re-establishes plan eligibility requirement (5) under applicable plan	Add dependent who satisfies plan eligibility requirement (12)
Change in Residence	
Employee or spouse changes primary (6) residence and becomes ineligible for current benefit election	No Change
Other Events	
Loss of other group health insurance coverage or health insurance coverage that entitles employee or family member to be enrolled under HIPAA Special Enrollment Rights	Add employee (1) (10) (11) (12) *or* ----------Add spouse and/or dependent (1) (10) (11) (12)
Judgment, decree, or administrative order relating to health coverage for child	Add child if required under order (10) (11) (12) *or* ---------- Drop child if other parent provides coverage under order (12)
Employee, spouse, or dependent enrolled in employer's health plan becomes entitled to Medicare or Medicaid	Make an election change that corresponds to the event (10) (12)
Employee, spouse, or dependent loses entitlement to Medicare, Medicaid, KCHIP, any governmental group health insurance coverage	Commence or increase coverage of that employee, spouse, or dependent (1) (10) (11) (12)
Cost or Coverage Changes (8)	
Change in Cost	
Benefit option has significant increase or decrease in cost	
Change In Coverage Under Another Employer Plan	
Employee's spouse makes elections during an open enrollment period that differs from the open enrollment period of the employer (7) ---------- **Employee makes elections during an open enrollment period of another employer that differs from the open enrollment period of the employer (7)**	Employee can make election change that "corresponds" with spouse's election change (10) ---------- Employee can make election change that corresponds with the elections made with the other employer's plan (10)

Event	*Accident or Health Plan Covering Expenses of Employee, Spouse, Eligible Dependents*
---------- **Retiree makes elections during an open enrollment period of a state sponsored retirement system that differs from the open enrollment period of the employer**	----------Retiree can make an election change that corresponds with the elections made with the retirement system plan (10)
Individual changes election for any other event that is permitted under regulation (and terms of the employer plan)	Employee can make election change that "corresponds" with election change (10)

Permitted Election Changes

End Notes:

(1) The final regulation preamble indicates that dependents who can be added are those who were directly affected by the status change event plus other dependents (the so-called "tag-along" rule). However, the examples in the regulation only explicitly deal with situations where an employee elects family coverage and adds family members at no additional cost. It is not clear, but IRS staff members have informally stated that the "tag-along" rule applies even if the employee must increase an election to add additional dependents. Also, the preamble and examples in the regulation indicate that the "tag-along" rule applies to HIPAA events and situations where a spouse terminates employment; it is not clear what other events might be covered by the "tag-along" rule.

(2) It appears this rule does not require that a spouse's coverage include a Health FSA.

(3) By an increase or decrease in dependent care expenses, we mean that the event increases or decreases the amount of expenses that an employee can have reimbursed on a tax-free basis under Code section 129 from a dependent care assistance plan. For example, if the employee gets married and his or her spouse does not work outside the home, the spouse would be available to care for a child, and thus the employee may not be able to claim that dependent care expenses are being used to enable the employee to be gainfully employed — a condition that must be satisfied for the expense to be reimbursed on a tax-free basis under Code section 129. Conversely, the marriage can increase the amount of expenses reimbursable under the dependent care assistance plan if, for example, a new spouse or stepchild is a "qualifying individual" for whom dependent care assistance can be received. A spouse's death or divorce might lead to fewer dependent care expenses eligible for reimbursement under section 129 if, for example, the spouse was a "qualifying individual." Conversely, if the spouse was not employed outside the home, the death or divorce might require the employee to pay for a caregiver in order to remain gainfully employed, and therefore the expenses may be reimbursed on a tax-free basis under section 129.

(4) Most employees are entitled to certain rights under the Family and Medical Leave Act (FMLA), whether or not the benefits are provided through a cafeteria plan. Employees generally must receive up to 12 weeks of unpaid FMLA leave, although the employee or employer generally can choose to substitute available paid leave for unpaid leave. During FMLA leave, the employer must maintain group health coverage (including FSA coverage) on the same conditions as coverage would be provided if the employee had not taken the leave. An employee's entitlement to other benefits during FMLA leave is determined by the employer's established policy for providing such benefits when the employee is on other forms of paid or unpaid leave (as appropriate). If benefits are continued during unpaid leave, proposed IRS regulations allow benefits purchased through a cafeteria plan to be paid in several ways, including increased salary reductions before the leave to prepay benefits or using salary reductions after the leave to "catch-

up" on payments. Benefits continued on paid FMLA leave are paid for in the same manner as during any paid leave. Employees can choose to drop benefits while on leave, but FMLA requires they have the right to be reinstated upon return from leave.

(5) For purposes of eligibility in this plan, a divorced dependent is not an "unmarried" dependent.

(6) Primary residence is the official residence claimed for tax purposes.

(7) Military Insurance Coverage, which does not include Veteran's Administration benefits, is considered "Another Employer Plan".

(8) "Cost or Coverage Changes under the Employer's Plan" are not included in this chart. In the event there is a mid-year change in the health plan, specific direction will be provided to the group or groups affected.

(9) An employee must request the mid-year election change within 30 days of the return to work date.

(10) Supporting documentation required.

(11) HIPAA Special Enrollment Right

(12) Qualifying Event permits change in plan option (Essential, Enhanced, or Premier).

EFFECTIVE DATES

Effective dates for the various mid-year election changes are as follows:

A. Events increasing coverage
   1. Birth, adoption, placement for adoption = date of the event;
   2. Marriage, loss of other coverage, court or administrative orders for dependent(s) or foster child(ren), expiration of COBRA = 1st day 1st month from the employee signature date.
   3. Different Open Enrollment = 1st day 1st of month (match effective date of other employer's plan)

B. Events decreasing coverage
   1. Death = date of the event.
      a. death of the employee with dependents = end of month in which death occurred
      b. death of employee no dependents = date of death
      c. death of dependent = date of death
   2. Divorce, loss of dependent status = End of the month of loss of eligibility.
   3. Gaining other health insurance coverage (Medicare/Medicaid/Tricare/etc.) = End of the month from the employee's signature date.
   4. Different Open Enrollment = Last day of the month (match other employer's plan).

All Qualifying Events must be signed by the employee 30-days from the date of the Qualifying Event, except for birth, adoption, or placement for adoption when adding the newly acquired dependent only, which is 60-days. However, the employee may sign Qualifying Events dealing with loss or gaining of other group coverage or health insurance prior to the Qualifying Event date.