

**Commonwealth of Kentucky
Personnel Cabinet
Department for Employee Insurance**



Pick the Health Insurance Plan
that best meets your needs.

Open Enrollment is
October 15 - 26, 2007

**2008 Plan Year
Kentucky Employees Health Plan
Handbook**

<http://kehpn.ky.gov>

TABLE OF CONTENTS

| | |
|---|-----|
| GENERAL INFORMATION | 1 |
| AVAILABLE ONLINE RESOURCES | 3 |
| MEMBER RESPONSIBILITIES | 4 |
| OPEN ENROLLMENT INFORMATION | 7 |
| BENEFIT FAIRS | 8 |
| PREMIUM INFORMATION | 10 |
| HEALTH INSURANCE PLAN OPTIONS | 13 |
| EXAMPLES OF HOW THE COMMONWEALTH SELECT PLAN WORKS | 18 |
| BENEFITS GRID | 23 |
| EXCLUSIONS | 28 |
| GENERAL BENEFITS INFORMATION | 30 |
| PRESCRIPTION DRUG BENEFITS | 32 |
| INFORMED CARE MANAGEMENT | 38 |
| KEHP WELLNESS PROGRAMS | 40 |
| WAIVING COVERAGE AND HEALTH REIMBURSEMENT | |
| ACCOUNTS FOR ACTIVE EMPLOYEES ONLY | 48 |
| ENROLLMENT APPLICATION | 51 |
| COMMONWEALTH CHOICE FLEXIBLE SPENDING ACCOUNTS (FSAs) | 56 |
| HUMANA ACCESS VISA CARD | 60 |
| MEDICAL CLAIMS APPEALS | 62 |
| HUMANA | 66 |
| HUMANA PRIVACY NOTICE | 68 |
| EXPRESS SCRIPTS | 69 |
| ONLINE ENROLLMENT | 70 |
| NOTICE OF CREDITABLE COVERAGE | 78 |
| ELIGIBILITY AND ENROLLMENT | 79 |
| FAMILY CROSS-REFERENCE PAYMENT OPTION | 83 |
| EFFECTIVE DATES | 84 |
| TERMINATION DATES | 85 |
| QUALIFYING EVENTS (for Health Insurance only) | 86 |
| HOW DO I KNOW WHICH FORM TO USE? | 92 |
| ELIGIBILITY AND ENROLLMENT GRIEVANCES | 93 |
| COBRA | 94 |
| TERMS YOU NEED TO KNOW | 95 |
| HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 | 98 |
| IMPORTANT INFORMATION FOR RETIREES | 100 |
| PHONE NUMBERS AND WEB SITES | 105 |

GENERAL INFORMATION

Disclaimer

The material contained in this Handbook is for *informational purposes only* and is not a contract. This Handbook is intended to highlight the benefits of and the eligibility requirements for the benefit plans. Review your Summary Plan Description (SPD) for detailed information, as that is your contract. Every effort has been made to ensure accuracy. If there is a difference between this information and any federal law, the federal law governs. Additionally, should there be a difference between any oral representation provided and any federal law, the federal law governs. It is your responsibility to read all materials provided in order to fully understand the provisions of the option selected.

Penalties for misrepresentation

If you, or your dependents, misrepresent information when applying for coverage, applying for a change in coverage or filing for benefits, the Department for Employee Insurance or your Third Party Administrator (TPA) may take adverse action against you. This includes, but is not limited to, terminating coverage (for you and/or your dependents) and/or imposing liability for fraud or indemnification (requiring payment for benefits to which you and/or your dependents were not entitled).

In order to avoid enforcement of any penalties, you must notify the Department for Employee Insurance immediately when you or your dependents are no longer eligible for coverage or if you have questions about eligibility.

Contact information

The Personnel Cabinet's Department for Employee Insurance is responsible for the administration of the Kentucky Employees Health Plan (KEHP). However, the Department for Employee Insurance does not make clinical determinations related to your claims. The Department for Employee Insurance has contracted with Humana (for physician, hospital, lab, etc.) and Express Scripts, Inc. (for pharmacy) to administer all claims.

GENERAL INFORMATION (CONTINUED)

Following is the contact information for our Third Party Administrators and the Department for Employee Insurance. Although Humana and Express Scripts are separate companies, for your convenience we have one toll-free number to contact both.

| If you have questions about: | You need to contact: |
|---|---|
| <ul style="list-style-type: none"> ● Obtaining medical provider directories ● Medical claims ● ID cards ● Informed Care Management Programs ● Personal Health Assessment (PHA) | Humana Insurance Company and its Affiliates (877) 597-KYSPiRiT (877) 597-7474 |
| <ul style="list-style-type: none"> ● Flexible Spending Account Claims <ul style="list-style-type: none"> ■ Healthcare FSA claims ■ Dependent Care FSA Claims ● Health Reimbursement Accounts (HRA) ● HumanaAccess® Visa® Debit Card | Humana Spending Account Administration (800) 604-6228 (800) 905-1851 (FAX) |
| <ul style="list-style-type: none"> ● Prescription drug formulary ● Participating pharmacies ● Prescription drug claims ● Step therapy ● Prior Authorization ● CuraScript Specialty Pharmacy ● Mail Order Prescription Program | Express Scripts, Inc. (877) 597-KYSPiRiT (877) 597-7474 |
| <ul style="list-style-type: none"> ● Medical or pharmacy benefits ● Eligibility ● Enrollment ● Qualifying Events ● Address Changes ● Smoking Cessation Program | Department for Employee Insurance Member Services Branch (502) 564-6534 (888) 581-8834 (502) 564-5278 FAX |
| <ul style="list-style-type: none"> ● Flexible Spending Accounts <ul style="list-style-type: none"> ■ Healthcare FSA ■ Dependent Care FSA ● Health Reimbursement Accounts (HRA) | Department for Employee Insurance Flexible Benefits Branch (502) 564-0350 (502) 564-0351 (502) 564-0364 FAX |

AVAILABLE ONLINE RESOURCES

<http://kehp.ky.gov>

You can find useful information at the click of a button!

- ☞ Link to our web enrollment system *Your KEHP Online Access* - to help you make your health insurance and FSA elections quickly and securely!
- ☞ This KEHP Handbook
- ☞ Medical and Pharmacy Summary Plan Descriptions (SPD) - your SPD is your guide to understanding your Plan's covered benefits, limitations and exclusions. Select the SPD for the Plan in which you are enrolled.
- ☞ SPDs for Healthcare FSA and Dependent Care FSA - these contain in-depth information regarding these employee funded programs.
- ☞ Health Reimbursement Account (HRA) SPD - available for those who waive health insurance coverage through the KEHP.
- ☞ The KEHP Administration Manual - designed for Insurance Coordinators as a guide to assist in the proper administration of the KEHP. We encourage you to access this comprehensive tool!
- ☞ Useful links to Humana, Express Scripts, Kentucky Retirement Systems and Kentucky Teachers' Retirement System.

- ☞ Enrollment forms - such as the Enrollment Application, Dependent Add and Dependent Drop Forms, Update Form, Post-Tax Request Form, Health Reimbursement Account and FSA Claim Form, etc.

www.humana.com

- ☞ Access to medical, Healthcare FSA, Dependent Care FSA and HRA claim information
- ☞ Personal Health Assessment (PHA)
- ☞ Health Information, including discounts
- ☞ Summary Plan Descriptions

www.express-scripts.com

- ☞ Pharmacy claim information
- ☞ Refill mail order prescriptions
- ☞ Estimate drug cost

Note:

Both Humana and Express Scripts web sites are secured sites and you must register on each site before accessing information.

MEMBER RESPONSIBILITIES

Read all information carefully

It is your responsibility to know what benefits are covered, how they are covered and when they are covered. You should direct your questions to the Department for Employee Insurance, Humana or Express Scripts. The Summary Plan Descriptions are available on the web site at <http://kehpn.ky.gov>. Review all information you receive from the Department for Employee Insurance, Humana or Express Scripts. Before you have medical services performed, make sure they have been pre-certified, when applicable. Payment for non-covered services is your responsibility.

Plan your decisions wisely

Study the Benefits Grid on pages 23 - 27 to determine which option best suits you and your family's needs.

Review the Premium Information on page 10 and determine the amount, if any that will be deducted from your paycheck. Once you have made your selections during Open Enrollment, you will not be allowed to make changes unless you experience a Qualifying Event that would allow a change, or you have a break in employment of **thirty (30) days or more**. For specific information on Qualifying Events, refer to pages 86-91.

Enroll no later than October 26, 2007

Open Enrollment is October 15, 2007 through October 26, 2007. The 2008 Plan Year is not a total re-enrollment.

You **MUST** enroll if:

- you want to enroll in or continue participating in an FSA;
- you want to waive coverage, or continue waiving coverage and direct the employer contribution to an HRA;
- you want to change your current health insurance plan; or
- you want to add or drop dependents.

FEDERAL REGULATIONS REQUIRE EMPLOYEES PARTICIPATING IN AN FSA TO RE-ENROLL EVERY YEAR.

YOU WILL NOT HAVE AN HRA OR FSA FOR THE 2008 PLAN YEAR IF YOU DO NOT ENROLL OR RE-ENROLL EACH YEAR.

If you are an employee of a health department or a quasi governmental agency, you must contact your Insurance Coordinator for FSA enrollment information.

MEMBER RESPONSIBILITIES (CONTINUED)

Verify that your elections are correct

Enrolling online will provide you with an immediate summary of your elections. **It is your responsibility to review and accept your elections. You should also print your confirmation, which includes your benefit information and specific premium information.**

Verify that your deductions are correct

It is your responsibility to review your first check for your 2008 Plan Year deductions. If your deductions do not match the elections you made during Open Enrollment, contact your agency's Insurance Coordinator **immediately**. If the deductions do match your elections, no changes will be allowed.

If you are an employee of a state agency you will see your 2008 health insurance deductions on your December 15th paycheck and your Flexible Spending Account deductions on your January 15th paycheck.

If you are an employee of a board of education you will see your 2008 health insurance deductions on your December paychecks and your Flexible Spending Account deductions either at the end of December or the first paycheck in January.

If you are an employee of a local health department you will see your 2008 health insurance deductions on your December

paychecks. You should contact your agency Insurance Coordinator for information regarding your Flexible Spending Account deductions.

If you are an employee of a quasi governmental agency you should check with your payroll officers or HR Administrators for 2008 benefit deduction dates.

Notify your agency's Insurance Coordinator of any eligibility changes

You must notify your agency's Insurance Coordinator if you experience life changing events (Qualifying Events) that may impact eligibility for you or your dependent(s). This includes, but is not limited to:

- Birth;
- Adoption or placement for adoption;
- Marriage, divorce, legal separation, annulment;
- Death of spouse or dependent;
- Dependent child reaches the limiting age;
- An employment status change for you, your spouse, or your dependent(s) that affects eligibility under the Plan;
- Spouse or dependent becomes covered by another group health plan.

You only have a **limited amount of time** to enroll or terminate coverage as a result of a Qualifying Event. Refer to the Qualifying Event chart in the Summary Plan Description for further information.

MEMBER RESPONSIBILITIES (CONTINUED)

Review your FSA information

If you are an employee of a state agency or school board you are eligible for participation in the Commonwealth Choice Flexible Spending Account Program. Refer to the Commonwealth Choice FSA section in this Handbook for additional information.

If you are an employee of a local health department or a quasi governmental agency, you must contact your Insurance Coordinator for details. Not all quasi governmental agencies participate in the Commonwealth Choice Flexible Spending Program.

Retirees are not eligible to participate in either the Flexible Spending Account program or the Health Reimbursement Account.



Summary of member responsibilities

- _____ Read all material received from the Department for Employee Insurance, Humana and Express Scripts.
- _____ Plan your decisions wisely
- _____ Enroll (Refer to page 4 to determine if you must enroll).
- _____ Review your confirmation to ensure that your elections are accurate.
- _____ Print your confirmation (if you enroll online).
- _____ Verify your deductions.

OPEN ENROLLMENT INFORMATION

Open Enrollment dates

Open Enrollment is October 15 - October 26, 2007. You must enroll online or complete and sign your Enrollment Application and submit it to your agency's Insurance Coordinator by October 26, 2007.

Is it required that I enroll for 2008?

You **MUST** enroll if:

- you want to enroll or continue participating in an FSA;
- you want to waive coverage, or continue waiving coverage, and direct the employer contribution to an HRA;
- you want to change your current health insurance plan; or
- you want to add or drop dependents.

You do not need to enroll if:

- you wish to maintain your current health insurance coverage - (Commonwealth Essential, Commonwealth Enhanced Commonwealth Premier or Commonwealth Select).

Health Reimbursement Accounts (HRA) and Flexible Spending Accounts (FSA) are not considered health insurance coverage. Therefore, if you want to enroll or continue to participate in an FSA, you must re-enroll during the Open Enrollment period. Also, if you want to waive coverage, or continue waiving coverage and direct the

employer contribution to an HRA, you must re-enroll during the Open Enrollment Period.

You may enroll online, unless you are:

- A KRS or KTRS retiree;
- Paying by cross-reference with a KRS or KTRS retiree;
- A retiree who has returned to work;
- A new employee who has not yet enrolled for 2007; or
- Switching the "primary" planholder on a cross-reference payment option.

If you are one of the above, you must complete the Enrollment Application and submit it to your Insurance Coordinator.

Waiving health insurance coverage

If you wish to waive coverage for 2008, you may do so online, or you may complete an Enrollment Application and indicate that you are electing to waive your health insurance coverage by completing Sections I, V, and VIII of the Enrollment Application.

Remember, if you wish to waive and direct the employer contribution to an HRA, you must re-enroll during Open Enrollment, even if you currently waive and have an HRA.

Refer to pages 48-50 of this Handbook for information on directing the employer contribution into an HRA.

BENEFIT FAIRS

The time and location for the eighteen (18) Benefit Fairs is listed below. You are strongly encouraged to participate in the Benefit Fair closest to you. Employees from the Department for Employee Insurance, Humana and Express Scripts will be available at each of the following Benefit Fairs to answer any questions you may have.

October 2
Franklin County
8:00 a.m. - 6:00 p.m.
Frankfort Convention Center
405 Mero Street
Frankfort, KY

October 3
Calloway County
2:00 p.m. - 6:00 p.m.
Calloway County Board of Education
Board Meeting Room
2110 College Farm Road
Murray, KY

October 3
Jefferson County
8:00 a.m. - 6:00 p.m.
Kentucky Fair & Exposition Center
West Hall Meeting Rooms 1 & 2
Louisville, KY

October 4
Pulaski County
2:00 p.m. - 6:00 p.m.
The Center for Rural Development
2292 South Hwy 27, Suite 300
Somerset, KY

October 4
Christian County
2:00 p.m. - 6:00 p.m.
Christian County Board of Education
Board Room
200 Glass Avenue
Hopkinsville, KY

October 5
Boyle County
2:00 p.m. - 6:00 p.m.
Inter-County Energy Cooperative
1009 Hustonville Rd
Danville, KY

October 5
Rowan County
2:00 p.m. - 6:00 p.m.
Rowan County Board of Education
Central Office Board Room
121 East 2nd Street
Morehead, KY

October 8
Hardin County
2:00 p.m. - 6:00 p.m.
New Highland Elementary Library
110 W.A. Jenkins Road
Elizabethtown, KY

October 8
McCracken County
2:00 p.m. - 6:00 p.m.
Western KY Community & Tech College
Crouse Hall Atrium
4810 Alben Barkley Drive
Paducah, KY

BENEFIT FAIRS (CONTINUED)

October 9

Pike County

2:00 p.m. - 6:00 p.m.
Pike Central High School
Conference Room
100 Winners Circle
Pikeville, KY

October 9

Hopkins County

2:00 p.m. - 6:00 p.m.
Madisonville North Hopkins High School
Library
4515 Hanson Road
Madisonville, KY

October 10

Daviess County

2:00 p.m. - 6:00 p.m.
Daviess County Public Schools Learning
Center
700 Parrish Plaza Drive
Owensboro, KY

October 10

Madison County

2:00 p.m. - 6:00 p.m.
Madison Central High School
705 North Second Street
Richmond, KY

October 11

Warren County

2:00 p.m. - 6:00 p.m.
Greenwood High School Library
5065 Scottsville Road
Bowling Green, KY

October 11

Boyd County

2:00 p.m. - 6:00 p.m.
Boyd County Middle School Theater
1226 Summit Road
Ashland, KY

October 12

Kenton County

2:00 p.m. - 6:00 p.m.
Northern KY Area Development District
22 Spiral Drive
Florence, KY

October 12

Whitley County

2:00 p.m. - 6:00 p.m.
Whitley County Board of Education
Board Office
300 Main Street
Williamsburg, KY

October 17

Fayette County

4:00 p.m. - 8:00 p.m.
Dunbar High School Cafeteria
1600 Man O War
Lexington, KY

PREMIUM INFORMATION

Premium conversion - (does not apply to retirees)

Upon enrollment, you are automatically set up to have your health insurance premiums deducted on a pre-tax basis. If you do not wish to have premiums deducted on a pre-tax basis, you must sign the "Post Tax Request Form". You may find this form on our web site at <http://kehp.ky.gov>, or you may contact the Department for Employee Insurance.

Employee contributions

Monthly employee contribution* - Non-Smoker

| | Single | Couple | Parent Plus | Family | Family Cross-Reference* |
|------------------------|-------------|----------|-------------|----------|-------------------------|
| Commonwealth Essential | Not offered | \$290.84 | \$61.64 | \$358.80 | \$0 |
| Commonwealth Enhanced | \$0 | \$400.90 | \$127.76 | \$481.10 | \$10.90 |
| Commonwealth Premier | \$20.40 | \$446.80 | \$190.94 | \$532.08 | \$37.08 |
| Commonwealth Select | \$0 | \$302.10 | \$98.26 | \$361.38 | \$8.18 |

Monthly employee contribution* - Smoker

| | Single | Couple | Parent Plus | Family | Family Cross-Reference* |
|------------------------|-------------|----------|-------------|----------|-------------------------|
| Commonwealth Essential | Not offered | \$324.48 | \$95.26 | \$392.42 | \$16.80 |
| Commonwealth Enhanced | \$16.80 | \$434.52 | \$161.38 | \$514.72 | \$27.70 |
| Commonwealth Premier | \$37.20 | \$480.42 | \$224.56 | \$565.70 | \$53.88 |
| Commonwealth Select | \$13.22 | \$327.44 | \$124.12 | \$386.66 | \$20.80 |

* Contribution is per employee

Refer to page 83 for additional information on the cross-reference payment option.

PREMIUM INFORMATION (CONTINUED)

Total premiums

The following charts are for reference only and do not reflect the amounts that will be deducted from your pay check.

| | Single | Couple | Parent Plus | Family |
|------------------------|----------|------------|-------------|------------|
| Commonwealth Essential | N/A | \$947.44 | \$617.12 | \$1,056.56 |
| Commonwealth Enhanced | \$484.24 | \$1,137.18 | \$742.74 | \$1,267.40 |
| Commonwealth Premier | \$501.20 | \$1,175.32 | \$772.06 | \$1,309.76 |
| Commonwealth Select | \$469.00 | \$989.18 | \$703.50 | \$1,128.48 |

Employer contributions

Monthly employer contribution - Non-Smoker

| | Single | Couple | Parent Plus | Family | Family Cross-Reference* |
|------------------------|----------|----------|-------------|----------|-------------------------|
| Commonwealth Essential | N/A | \$656.60 | \$555.48 | \$697.76 | \$528.28 |
| Commonwealth Enhanced | \$484.24 | \$736.28 | \$614.98 | \$786.30 | \$622.80 |
| Commonwealth Premier | \$480.80 | \$728.52 | \$581.12 | \$777.68 | \$617.80 |
| Commonwealth Select | \$469.00 | \$687.08 | \$605.24 | \$767.10 | \$556.06 |

Monthly employer contribution - Smoker

| | Single | Couple | Parent Plus | Family | Family Cross-Reference* |
|------------------------|----------|----------|-------------|----------|-------------------------|
| Commonwealth Essential | N/A | \$622.96 | \$521.86 | \$664.14 | \$511.48 |
| Commonwealth Enhanced | \$467.44 | \$702.66 | \$581.36 | \$752.68 | \$606.00 |
| Commonwealth Premier | \$464.00 | \$694.90 | \$547.50 | \$744.06 | \$601.00 |
| Commonwealth Select | \$455.78 | \$661.74 | \$579.38 | \$741.82 | \$543.44 |

* Contribution is per employee

PREMIUM INFORMATION (CONTINUED)

Notice to Enrollees in The Commonwealth of Kentucky Flexible Benefits Plan (Commonly known as the Kentucky Employees Health Plan)

Under a Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, as amended, group health plans must generally comply with certain requirements. However, the law also permits state and local governmental employers that sponsor health plans to elect to exempt a plan from these requirements for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy. The Commonwealth of Kentucky has elected to exempt the Commonwealth of Kentucky Flexible Benefits Plan from the following requirement:

Prohibitions against discriminating against individual participants and beneficiaries based on health status. A group health plan may not discriminate in enrollment rules or in the amount of premiums or contributions it requires an individual to pay based on certain health status-related factors: health status, medical condition (physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability. **The sole differentiation among enrollees in the Commonwealth's Plan relates to the incentive, through a greater employer contribution, offered to enrollees that refrain from the use of tobacco products. No other health-related factors are used to distinguish enrollees.**

The exemption from this Federal requirement will be in effect for the 2008 Plan Year beginning January 1, 2008, and ending December 31, 2008. The election will be renewed for subsequent plan years.

Further information is available by contacting the Personnel Cabinet, Department for Employee Insurance, Member Services Branch at (888) 581-8834 or (502) 564-6534.

HEALTH INSURANCE PLAN OPTIONS

The KEHP is offering the same health insurance plan options as last year. Even though you may be familiar with these plan options, you should still carefully read the similarities and differences in each plan. If you need assistance in understanding the plan options, you may call Humana at 877-KYSPiRiT or the Department for Employee Insurance at (888) 581-8834.

There are four (4) plans being offered for the 2008 Plan Year (the Commonwealth Select Plan is not available to retirees). All four (4) plan options have the same covered services, exclusions and limitations. The primary differences in the plans are how much you will have to pay in premiums, and your out-of-pocket costs in co-payments, coinsurance and/or deductibles. You should refer to the Benefits Grid on pages 23-27 of this Handbook or the Summary Plan Description (SPD), which can be found at <http://kehpcy.gov> for specific information about each plan option.

The **Commonwealth Essential** plan option is a PPO plan that provides coverage for in-network and out-of-network medical and prescription benefits. All covered services are subject to the *deductible* and *coinsurance* amount, except routine care.

The **Commonwealth Enhanced** and **Commonwealth Premier** plan options are PPO plans that provide coverage for in-network and out-of-network medical and prescription benefits. You are responsible for paying a *co-payment* amount for office visits, lab and x-ray,

and prescription medications. Other services are subject to a deductible and coinsurance amount. The coinsurance and out-of-pocket maximums are slightly different in the two plans. However, you may want to look closely at the differences as the difference in premiums may offset most of the difference in the out-of-pocket maximums.

The **Commonwealth Select Plan** is different from the other three (3) plan options because it combines a PPO Consumer Driven Health Plan (CDHP) with a Health Reimbursement Account (HRA). This account is also referred to as a Personal Care Account (PCA). The HRA is embedded in the PPO plan. You will have health insurance coverage and an HRA all rolled into one plan. Since the Commonwealth Select Plan is a newer plan option for you to consider, we have provided additional information regarding this plan.

An HRA is an "expense account" funded by your employer. The amount your employer will contribute varies depending on the level of coverage you select (e.g. single, couple, parent plus or family).

Your employer will provide the following HRA funds:

| | |
|------------------|---------|
| Single Plan | \$1,000 |
| Couple Plan | \$1,500 |
| Parent Plus Plan | \$1,500 |
| Family Plan | \$2,000 |

If you elect the cross-reference payment option, you will receive the family plan HRA contribution (\$2,000).

HEALTH INSURANCE PLAN OPTIONS (CONTINUED)

The entire amount of the funding will be available beginning January 1, 2008. If you had the Commonwealth Select Plan in 2007 and have funds remaining in your HRA at the end of the 2007 Plan Year, those funds will “carry-over” and be combined with your 2008 HRA funds, if you continue with the Commonwealth Select Plan. All of your HRA funds will be available for use in future years - as long as you continue to elect the Commonwealth Select Plan each Open Enrollment. This is only one of the many benefits of this Plan. If you terminate the Commonwealth Select Plan for any reason (termination of employment, retirement, etc.), you will forfeit any unused funds in your HRA.

The Commonwealth Select Plan gives you choice and flexibility in how you pay for your healthcare needs. Along with the benefit of unused funds carrying over year after year, the following additional benefits are offered under this plan:

- Your funds from the HRA can be used for expenses that apply toward your deductible. Your deductible is reduced with funds supplied by your employer!
- You can access your HRA funds with the swipe of a card. When you’re at the pharmacy or physician’s office, you can just swipe your HumanaAccess card (refer to pages 60-61 for more details) to pay your coinsurance or deductible. The cost of the service is then directly taken from your HRA.
- Once you have met the out-of-pocket maximum for the year, the

plan will pay 100% of all remaining eligible expenses.

- Your prescription drug and office visit claims apply to your deductible and out-of-pocket maximum.

If you use all of your HRA funds, it’s your responsibility to pay for additional plan-covered medical expenses until you meet your deductible for the year. Once you have met the deductible, you pay only the coinsurance percentage for covered services specified in your SPD. Additionally, your out-of-pocket costs are capped so you’re protected against any major, unexpected medical expenses that are covered by your Plan.

Frequently Asked Questions about the Commonwealth Select Plan

Are retirees eligible for the Commonwealth Select Plan?

The Commonwealth Select plan is only available for active employees.

If I leave employment or retire, do any remaining funds in the HRA roll upon termination or retirement?

No. If you terminate employment, or retire, all HRA funds are forfeited as of your termination or retirement date.

HEALTH INSURANCE PLAN OPTIONS (CONTINUED)

If I choose the Commonwealth Select Plan for 2008, and have funds remaining at the end of the year, but choose another plan in 2009, will I retain the remaining funds in the HRA?

No. If you switch plans, any remaining HRA funds will be forfeited as of the termination date of the Commonwealth Select Plan.

Who will contribute the money to the HRA account?

The Commonwealth, or your employer, will fund the HRA account.

When my doctor files a claim, Humana sends me an Explanation of Benefits showing the "approved" amount, which is generally less than the amount my doctor charged. With the Commonwealth Select Plan, which amount will be deducted from my HRA account - the actual charge or the approved amount?

As long as you utilize in-network providers (par providers), the approved amount will be deducted from your HRA account.

My doctor requires payment at the time of service. If I use my HumanaAccess card and then receive the EOB and my liability is less than I was charged, what do I do?

If this occurs, you should first ask the doctor to refund the difference on your HumanaAccess card. If the provider refunds the difference to you and not

to your HumanaAccess card, it is your responsibility to refund that amount to be credited to your card. Remember, Humana must be able to balance and substantiate your card or you will be required to provide appropriate documentation.

When I go to my doctor, do I just have to show them my HumanaAccess card?

No. You must also show the provider your Humana identification card to ensure they file a claim with Humana (or Express Scripts for pharmacy claims). If the claims are not filed to Humana, they will not have the necessary information to process the claims. The HumanaAccess card is simply a Visa card that will draw the funds from your HRA account. However, Humana must have the claim in order to track your deductible and out-of-pocket costs.

Will I be able to have a Healthcare Flexible Spending Account to pay for other expenses and the coinsurance?

Yes. You can have a Healthcare Flexible Spending Account, in addition to the Health Reimbursement Account. However, your Flexible Spending Account money will always pay first.

HEALTH INSURANCE PLAN OPTIONS (CONTINUED)

Are the funds paid out of my FSA account applied toward my out-of-pocket maximum?

Yes. Any funds paid out of your Healthcare FSA for eligible covered expenses would count toward your out-of-pocket maximum. For instance, if you go to the doctor for the flu, and the funds are paid out of the FSA, the doctor would file the claim and it would apply toward your deductible and out-of-pocket. However, if you go to the dentist and those funds are paid out of the FSA, they will not apply to the deductible and out-of-pocket maximum as dental services are not covered under your health plan.

Will drug co-pays apply to the HRA funds?

With the Commonwealth Select Plan, all benefits are subject to the deductible and then coinsurance. For example, if you have a Single plan, any drug cost for the first \$1,000 would be deducted from the HRA. For the next \$1,000, you would pay the full cost of any medical expenses (drugs, physicians, hospitals, etc). After that, you would pay 10% of any costs including prescription drug costs. Express Scripts also has discounted costs for the prescription drugs. The discounted costs are the charges that would be applied to the HRA or deductible. Your coinsurance would be based on the discounted cost.

Will my coinsurance for prescriptions and doctor's office visits apply to the out-of-pocket maximum?

Yes. One of the advantages of the Commonwealth Select Plan is that once you meet your out-of-pocket maximum, all eligible expenses are paid at 100% - including your prescription drugs and office visits. With the other plans offered, even after you meet the out-of-pocket maximum, you continue to pay any co-pay amounts.

I am accustomed to having my office visits and prescriptions paid with a co-payment. I can better budget for those expenses. Why should I take the Commonwealth Select Plan when I will have to pay more for my office visits and prescriptions because I will not have the co-pay?

Each person will need to review his/her individual needs. Employees who have minimal medical costs will benefit from the Commonwealth Select Plan. Employees who have significant medical costs may benefit from this plan, as well.

You will need to consider how many times you go to the doctor, how many prescriptions you may take and estimate what your total medical cost would be for the year. You should also consider the difference in your premium cost. In some cases, when you consider the difference in the premium and your total out-of-pocket cost, it may cost you less to take a lower cost plan.

HEALTH INSURANCE PLAN OPTIONS (CONTINUED)

Will the HRA pay for services not covered by the plan? For example - eye glasses.

The HRA will reimburse some eligible expenses not covered by the health insurance plan (such as over-the-counter drugs, dental and vision). However, those expenses will not apply to the annual deductible and out-of-pocket maximum of the Commonwealth Select Plan because they are not eligible expenses under the Commonwealth Select Plan.

Am I permitted to continue my coverage under the Commonwealth Select Plan if I terminate my employment?

Yes, you are permitted to continue your coverage under the Commonwealth Select Plan if you experience a COBRA Qualifying Event and you enroll in COBRA continuation coverage. Unlike an FSA, the HRA funds will be permitted to roll over to the next calendar year; therefore, your COBRA coverage can cross-over to another Plan Year.

Note: In materials that you receive from Humana, an HRA may also be referred to as a Personal Care Account (PCA).

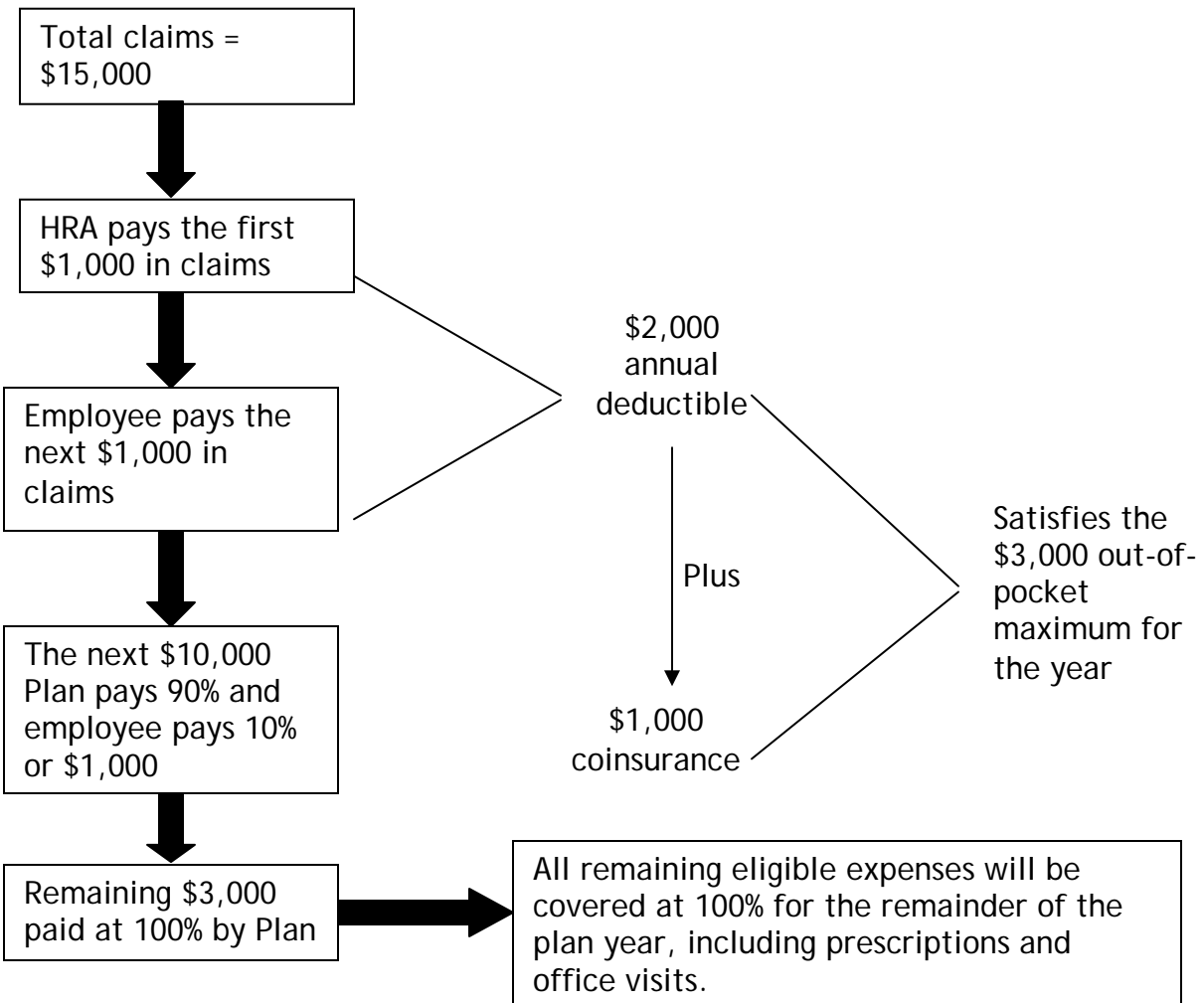
EXAMPLES OF HOW THE COMMONWEALTH SELECT PLAN WORKS

To better understand how the Commonwealth Select Plan works, we have provided you with the following examples.

Example 1

An employee with a single Commonwealth Select Plan whose total eligible annual healthcare expenses are \$15,000.

HRA funds = \$1,000
Single deductible = \$2,000
Out-of-pocket maximum = \$3,000

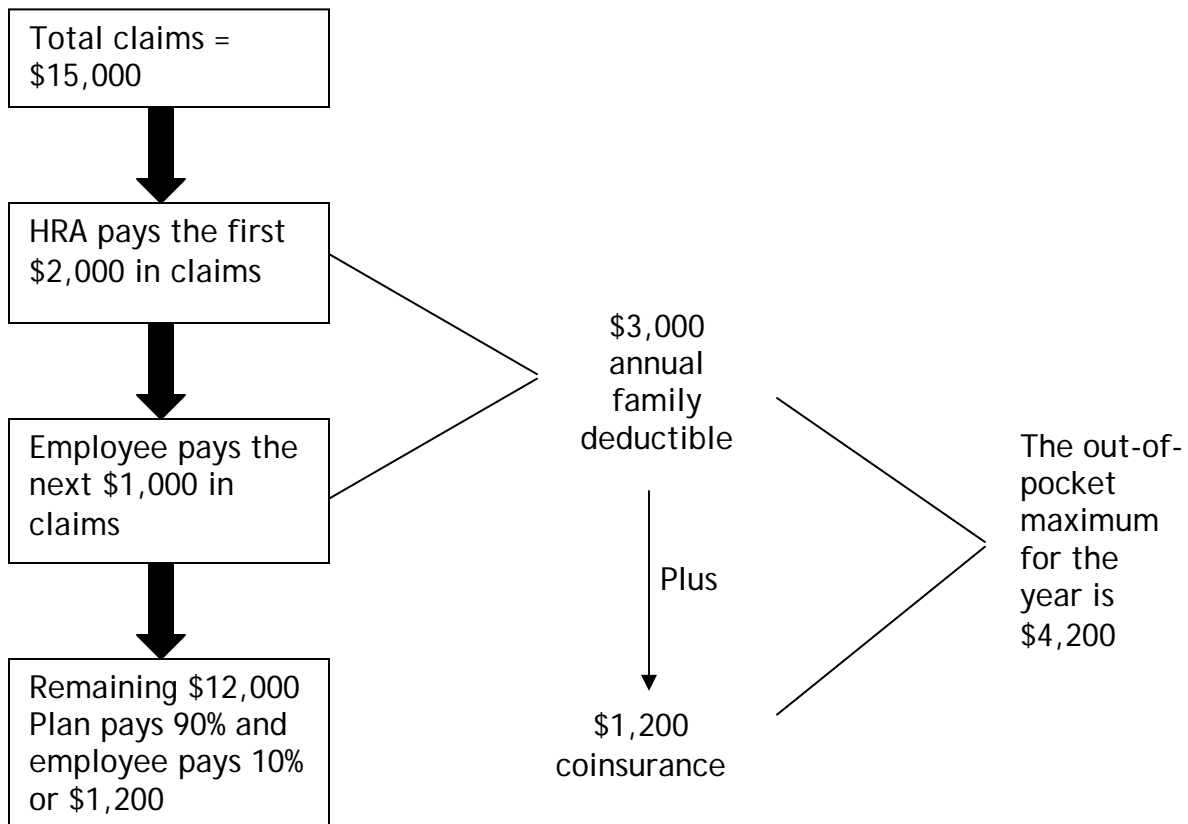


EXAMPLES OF HOW THE COMMONWEALTH SELECT PLAN WORKS (CONTINUED)

Example 2

An employee with a family Commonwealth Select Plan whose total eligible annual healthcare expenses are \$15,000.

HRA funds = \$2,000
Family deductible = \$3,000*
Out-of-pocket maximum = \$4,500



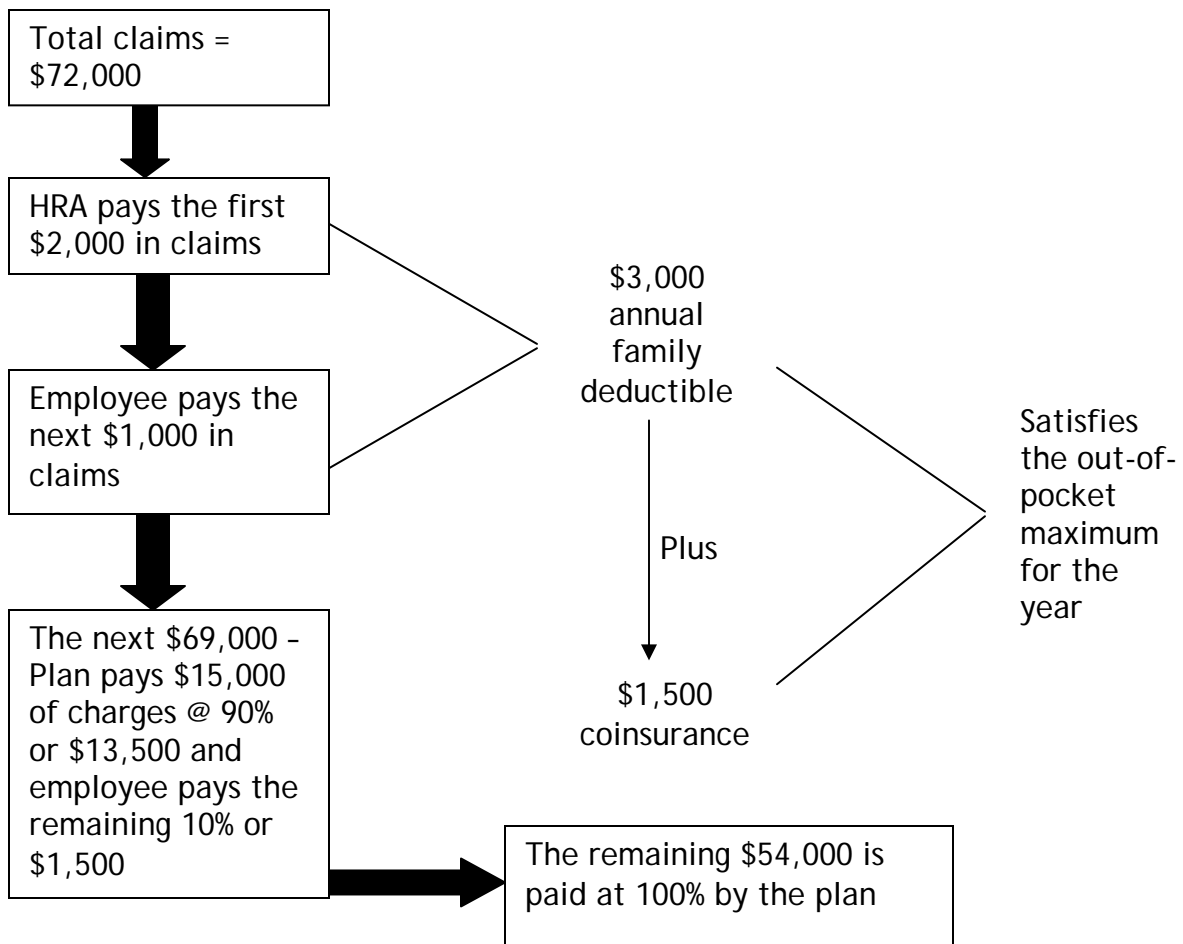
*Refer to page 31 for details on how the family deductible accumulates.

EXAMPLES OF HOW THE COMMONWEALTH SELECT PLAN WORKS (CONTINUED)

Example 3

An employee with a family Commonwealth Select Plan whose total eligible annual healthcare expenses are \$72,000.

HRA funds = \$2,000
 Family deductible = \$3,000*
 Out-of-pocket maximum = \$4,500



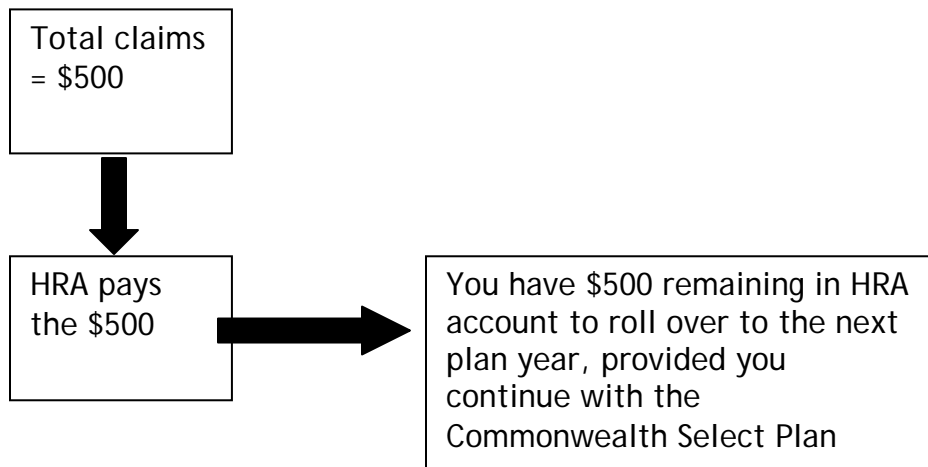
*Refer to page 31 for details on how the family deductible accumulates.

EXAMPLES OF HOW THE COMMONWEALTH SELECT PLAN WORKS (CONTINUED)

Example 4

A single employee with a single Commonwealth Select Plan whose total eligible annual healthcare expenses are \$500.

HRA funds = \$1,000
Single deductible = \$2,000
Out-of-pocket maximum = \$3,000

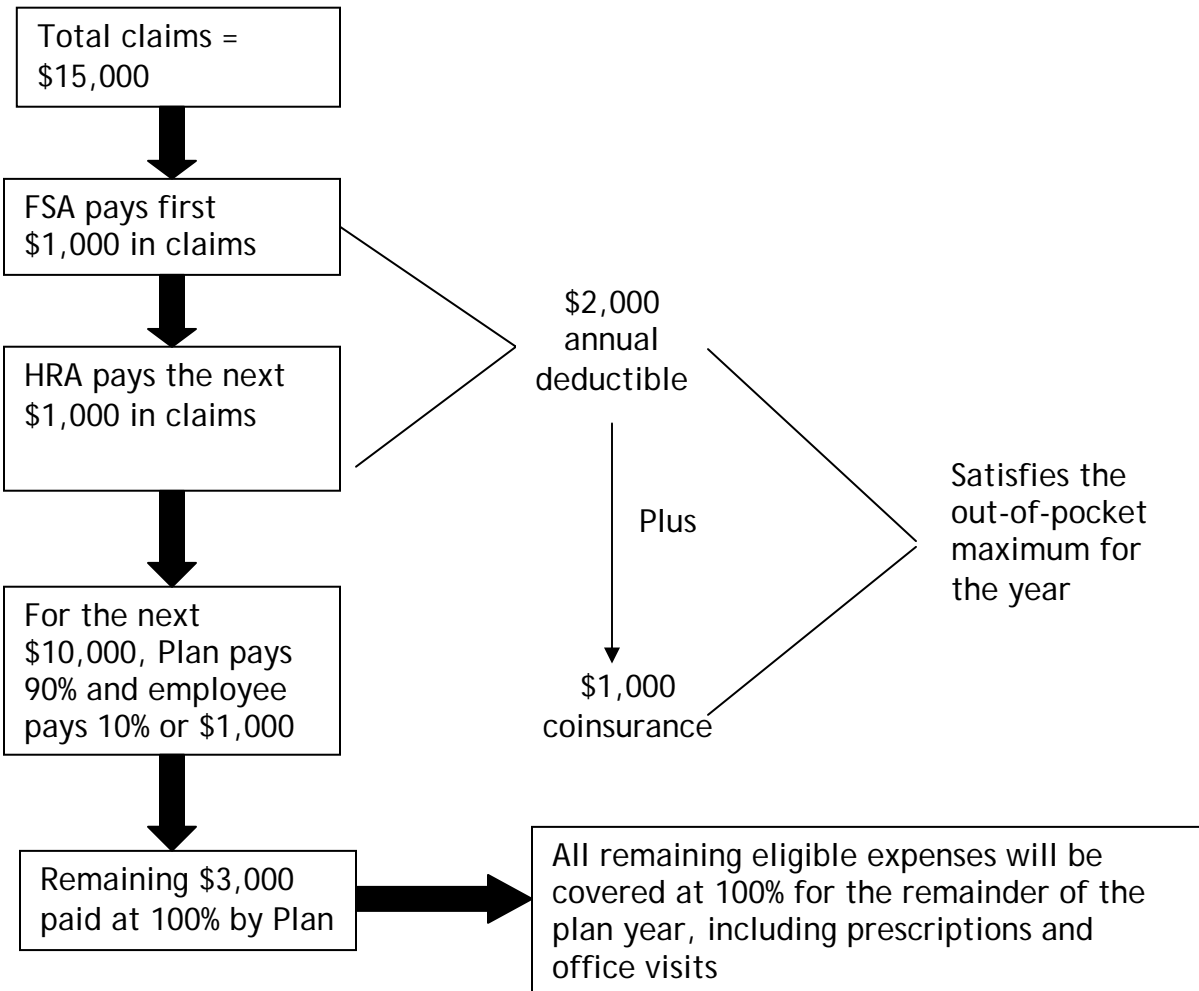


EXAMPLES OF HOW THE COMMONWEALTH SELECT PLAN WORKS (CONTINUED)

Example 5

An employee with a single Commonwealth Select Plan and a Healthcare Flexible Spending Account totaling \$1,000 whose total eligible annual healthcare expenses are \$15,000.

FSA funds = \$1,000
 HRA funds = \$1,000
 Single deductible = \$2,000
 Out-of-pocket maximum = \$3,000



BENEFITS GRID

| Benefit | Commonwealth Essential | | Commonwealth Enhanced | | Commonwealth Premier | | Commonwealth Select | |
|--|---|--------------------------------------|--|--------------------------------------|--|---------------------------------------|--|--------------------------------------|
| | In-network | Out-of-Network | In-network | Out-of-Network | In-network | Out-of-Network | In-network | Out-of-Network |
| Annual Deductible | Single - \$750 Family - \$1,500 | Single - \$1,500 Family - \$3,000 | Single - \$250 Family - \$500 | Single - \$500 Family - \$1,000 | Single - \$250 Family - \$500 | Single - \$500 Family - \$1,000 | Single - \$2,000 Family - \$3,000 | Single - \$2,000 Family - \$3,000 |
| Coinsurance | Plan pays - 75% You pay - 25% | Plan pays - 50% You pay - 50% | Plan pays - 80% You pay - 20% | Plan pays - 60% You pay - 40% | Plan pays - 90% You pay - 10% | Plan pays - 70% You pay - 30% | Plan pays - 90% You pay - 10% | Plan pays 60% You pay - 40% |
| Annual Out-of-Pocket Maximum | Single - \$3,500 Family, - \$7,000 | Single - 7,000 Family - \$14,000 | Single - \$1,250 Family - \$2,500 | Single - \$2,500 Family - \$5,000 | Single - \$1,000 Family - \$2,000 | Single - \$2,000 Family - \$4,000 | Single - \$3,000 Family - \$4,500 | Single - \$4,000 Family - \$6,000 |
| | Excludes prescription drug expenses and emergency room co-pays. | | Excludes prescription drug co-pays, office visit co-pays, emergency room co-pays and urgent care co-pays | | Excludes prescription drug co-pays, office visit co-pays, emergency room co-pays and urgent care co-pays | | All covered expenses apply to the out-of-pocket maximum | |
| Health Reimbursement Account Funds | Not Applicable | Not Applicable | Not Applicable | Not Applicable | Not Applicable | Not Applicable | Single - \$1,000 Parent Plus \$1,500 Couple - \$1,500 Family - \$2,000 Refer to page 13-22 for additional information on how the HRA works | |
| Lifetime Maximum | Unlimited | Unlimited | Unlimited | Unlimited | Unlimited | Unlimited | Unlimited | Unlimited |
| | Member Pays | Member Pays | Member Pays | Member Pays | Member Pays | Member Pays | Member Pays | Member Pays |
| Hospital Services | | | | | | | | |
| Inpatient Hospital (semi-private room) | Deductible then 25% | Deductible then 50% | Deductible then 20%* | Deductible then 40%* | Deductible then 10%* | Deductible then 30%* | Deductible then 10%* | Deductible then 40%* |
| Outpatient Surgery | Deductible then 25% | Deductible then 50% | Deductible then 20%* | Deductible then 40%* | Deductible then 10% | Deductible then 30%* | Deductible then 10%* | Deductible then 40%* |
| Outpatient Diagnostic X-ray and Lab | Deductible then 25% | Deductible then 50% | \$10 per provider/member/site | Deductible then 40%* | \$10 per provider/member/site | Deductible then 30%* | Deductible then 10%* | Deductible then 40%* |
| Pre-admission Testing | Deductible then 25% | Deductible then 50% | \$10 co-pay | Deductible then 40%* | \$10 co-pay | Deductible then 30%* | Deductible then 10%* | Deductible then 40%* |
| Emergency Room | \$50 co-pay then deductible and 25% | \$50 co-pay then deductible and 50% | \$50 co-pay plus 20%* | \$50 co-pay then 40%* | \$50 co-pay plus 10%* | \$50 co-pay then deductible plus 30%* | Deductible then 10%* | Deductible then 40%* |
| | Co-pay waived if admitted | | Co-pay waived if admitted | | Co-pay waived if admitted | | | |
| Emergency Room Physician | Deductible then 25% | Deductible then 50% | 20%* | 40%* | 10%* | Deductible then 30%* | Deductible then 10%* | Deductible then 40%* |
| Other Facility Services | | | | | | | | |
| Free Standing Surgical Facility | Deductible then 25%* | Deductible then 50%* | Deductible then 20%* | Deductible then 40%* | Deductible then 10%* | Deductible then 30%* | Deductible then 10%* | Deductible then 40%* |

BENEFITS GRID

| Benefit | Commonwealth Essential | | Commonwealth Enhanced | | Commonwealth Premier | | Commonwealth Select | |
|---|--|--|--|--|--|--|----------------------|----------------------|
| | In-network | Out-of-Network | In-network | Out-of-Network | In-network | Out-of-Network | In-network | Out-of-Network |
| Urgent Care Facility | Deductible then 25%* | Deductible then 50%* | \$20 co-pay | Deductible then 40%* | | Deductible then 30%* | Deductible then 10%* | Deductible then 40%* |
| Physician Services | | | | | | | | |
| Qualified Practitioner (Office Visits) | Deductible then 25%* | Deductible then 50%* | \$10 co-pay | Deductible then 40%* | \$10 co-pay | Deductible then 30%* | Deductible then 10%* | Deductible then 40%* |
| Qualified Practitioner (Other than Office Visits) | Deductible then 25%* | Deductible then 50%* | Deductible then 20%* | Deductible then 40%* | Deductible then 10%* | Deductible then 30%* | Deductible then 10%* | Deductible then 40%* |
| Injections (other than routine) | Deductible then 25%* | Deductible then 50%* | \$10 co-pay | Deductible then 40%* | \$10 co-pay | Deductible then 30%* | Deductible then 10%* | Deductible then 40%* |
| Diagnostic X-ray and Lab | | | | | | | | |
| Office setting (same site/same day as office visit) | Deductible then 25%* | Deductible then 50%* | Payable at 100% after office visit co-pay | Deductible then 40%* | Payable at 100% after office visit co-pay | Deductible then 30%* | Deductible then 10%* | Deductible then 40%* |
| Independent Lab | Deductible then 25%* | Deductible then 50%* | Payable at 100% after office visit co-pay | Deductible then 40%* | Payable at 100% after office visit co-pay | Deductible then 30%* | Deductible then 10%* | Deductible then 40%* |
| Outpatient x-ray | Deductible then 25%* | Deductible then 50%* | \$10 co-pay | Deductible then 40%* | \$10 co-pay | Deductible then 30%* | Deductible then 10%* | Deductible then 40%* |
| Inpatient setting | Deductible then 25%* | Deductible then 50%* | Deductible then 20%* | Deductible then 40%* | Deductible then 10%* | Deductible then 30%* | Deductible then 10%* | Deductible then 40%* |
| Emergency Room setting | Deductible then 25%* after emergency room co-pay | Deductible then 50%* after emergency room co-pay | Deductible then 20%* after emergency room co-pay | Deductible then 40%* after emergency room co-pay | Deductible then 10%* after emergency room co-pay | Deductible then 30%* after emergency room co-pay | Deductible then 10%* | Deductible then 40%* |
| Anesthesia and Surgery Services | | | | | | | | |
| Office or Clinic setting | Deductible then 25%* | Deductible then 50%* | \$10 office visit co-pay | Deductible then 40% | \$10 office visit co-pay | Deductible then 30%* | Deductible then 10%* | Deductible then 40%* |
| Inpatient or outpatient setting | Deductible then 25%* | Deductible then 50%* | Deductible then 20%* | Deductible then 40%* | Deductible then 10%* | Deductible then 30%* | Deductible then 10%* | Deductible then 40%* |
| Routine Child Care Ages 0 - 18 | | | | | | | | |
| Exam and Immunizations | Payable at 100% | Payable at 100% | \$10 co-pay | Deductible then 40%* | \$10 co-pay | Deductible then 30%* | Payable at 100% | Not Covered |
| Lab and X-ray (same site/same day as office visit) | Payable at 100% | Payable at 100% | Payable at 100% | Deductible then 40%* | Payable at 100% | Deductible then 30%* | Payable at 100% | Not Covered |

BENEFITS GRID

| Benefit | Commonwealth Essential | | Commonwealth Enhanced | | Commonwealth Premier | | Commonwealth Select | |
|---|------------------------|----------------------|---|----------------------|---|----------------------|-----------------------|----------------------|
| | In-network | Out-of-Network | In-network | Out-of-Network | In-network | Out-of-Network | In-network | Out-of-Network |
| Routine Adult Care Ages 18 and older | | | | | | | | |
| Exam and testing | Payable at 100% | Payable at 100% | \$10 co-pay | Deductible then 40%* | \$10 co-pay | Deductible then 30%* | Payable at 100% | Not Covered |
| <p style="color: red;">Sometimes during the course of a screening procedure (routine wellness or preventive care), abnormalities or problems may be identified that require immediate intervention or additional diagnosis. If this occurs, and your provider performs additional necessary procedures, the service will be considered diagnostic and/or surgical, rather than screening, depending on the claim for the services submitted by your provider. This may result in a possible difference in your co-pay and/or coinsurance.</p> | | | | | | | | |
| Lab and x-ray (same site/same day as office visit) | Payable at 100% | Payable at 100% | Payable at 100% | Deductible then 40%* | Plan pays 100% | Deductible then 30%* | Payable at 100% | Not Covered |
| Inpatient Newborn Benefits | | | | | | | | |
| Well newborn | 25%* | 50%* | 20% coinsurance* | 40% coinsurance* | 10% coinsurance* | 30% coinsurance* | Deductible then 10%* | Deductible then 40%* |
| Sick Newborn | Deductible then 25%* | Deductible then 50%* | Deductible then 20%* | Deductible then 40%* | Deductible then 10%* | Deductible then 30%* | Deductible then 10%* | Deductible then 40%* |
| Maternity Care | | | | | | | | |
| Prenatal care, labor, delivery, postpartum care, and one ultrasound per pregnancy (additional ultrasounds subject to prior plan approval) | Deductible then 25%* | Deductible then 50%* | \$10 co-pay (limited to office visit in which pregnancy is diagnosed). Delivery charge subject to Deductible then 20%* | Deductible then 40%* | \$10 co-pay (limited to office visit in which pregnancy is diagnosed). Delivery charge subject to Deductible then 10%* | Deductible then 30%* | Deductible then 10%* | Deductible then 40%* |
| Chemotherapy and Radiation Therapy | | | | | | | | |
| Office or Clinic Setting | Deductible then 25%* | Deductible then 50%* | \$10 co-pay | Deductible then 40%* | \$10 co-pay | Deductible then 30%* | Deductible then 10%* | Deductible then 40%* |
| Outpatient Hospital Setting | Deductible then 25%* | Deductible then 50%* | Deductible then 20%* | Deductible then 40%* | Deductible then 10%* | Deductible then 30%* | Deductible then 10%* | Deductible then 40%* |
| Miscellaneous Benefits | | | | | | | | |
| Autism Service | \$500 monthly maximum | | \$500 monthly maximum | | \$500 monthly maximum | | \$500 monthly maximum | |
| Rehabilitative and therapeutic care services | Deductible then 25%* | Deductible then 50%* | \$10 co-pay | Deductible then 40%* | \$10 co-pay | Deductible then 30%* | Deductible then 10%* | Deductible then 40%* |
| Therapy services for autism are payable under the specific therapy benefit first and once those limits are exhausted, services are covered under the autism benefit. | | | | | | | | |

BENEFITS GRID

| Benefit | Commonwealth Essential | | Commonwealth Enhanced | | Commonwealth Premier | | Commonwealth Select | |
|--|---|----------------------|---|----------------------|---|----------------------|---|----------------------|
| | In-network | Out-of-Network | In-network | Out-of-Network | In-network | Out-of-Network | In-network | Out-of-Network |
| Respite care children ages 2 through 21 | Deductible then 25%* | Deductible then 50%* | Deductible then 50%* | Deductible then 50%* | Deductible then 10%* | Deductible then 30%* | Deductible then 10%* | Deductible then 40%* |
| Ambulance Services | Deductible then 25%* | Deductible then 25%* | Deductible then 20%* | Deductible then 20%* | Deductible then 10%* | Deductible then 10%* | Deductible then 10%* | Deductible then 10%* |
| Skilled Nursing Facility | Deductible then 25%* | Deductible then 50%* | Deductible then 20%* | Deductible then 40%* | Deductible then 10%* | Deductible then 30%* | Deductible then 10%* | Deductible then 40%* |
| | Maximum of thirty (30) days per calendar year | | Maximum of thirty (30) days per calendar year | | Maximum of thirty (30) days per calendar year | | Maximum of thirty (30) days per calendar year | |
| Home Health Care | Deductible then 25%* | Deductible then 50%* | Deductible then 20%* | Deductible then 40%* | Deductible then 10%* | Deductible then 30%* | Deductible then 10%* | Deductible then 40%* |
| | Maximum of sixty (60) visits per calendar year | | Maximum of sixty (60) visits per calendar year | | Maximum of sixty (60) visits per calendar year | | Maximum of sixty (60) visits per calendar year | |
| Hospice Care | Same as Medicare | | Same as Medicare | | Same as Medicare | | Same as Medicare | |
| Physical Therapy | Deductible then 25%* | Deductible then 50%* | Deductible then 20%* | Deductible then 40%* | Deductible then 10%* | Deductible then 30%* | Deductible then 10%* | Deductible then 40%* |
| | Maximum of thirty (30) visits per calendar year | | Maximum of thirty (30) visits per calendar year | | Maximum of thirty (30) visits per calendar year | | Maximum of thirty (30) visits per calendar year | |
| Occupational Therapy | Deductible then 25%* | Deductible then 50%* | Deductible then 20%* | Deductible then 40%* | Deductible then 10%* | Deductible then 30%* | Deductible then 10%* | Deductible then 40%* |
| | Maximum of thirty (30) visits per calendar year | | Maximum of thirty (30) visits per calendar year | | Maximum of thirty (30) visits per calendar year | | Maximum of thirty (30) visits per calendar year | |
| Speech Therapy | Deductible then 25%* | Deductible then 50%* | Deductible then 20%* | Deductible then 40%* | Deductible then 10%* | Deductible then 30%* | Deductible then 10%* | Deductible then 40%* |
| | Maximum of thirty (30) visits per calendar year | | Maximum of thirty (30) visits per calendar year | | Maximum of thirty (30) visits per calendar year | | Maximum of thirty (30) visits per calendar year | |
| Cardiac Rehabilitation Therapy (Phase I and II) | Deductible then 25%* | Deductible then 50%* | Deductible then 20%* | Deductible then 40%* | Deductible then 10%* | Deductible then 30%* | Deductible then 10%* | Deductible then 40%* |
| | Maximum of thirty (30) visits per calendar year | | Maximum of thirty (30) visits per calendar year | | Maximum of thirty (30) visits per calendar year | | Maximum of thirty (30) visits per calendar year | |
| Rehabilitation Centers | Deductible then 25%* | Deductible then 50%* | Deductible then 20%* | Deductible then 40%* | Deductible then 10%* | Deductible then 30%* | Deductible then 10%* | Deductible then 40%* |
| Hearing Aids (Covered persons under 18 years of age) | Deductible then 25%* | Deductible then 50%* | Deductible then 20%* | Deductible then 40%* | Deductible then 10%* | Deductible then 30%* | Deductible then 10%* | Deductible then 40%* |
| | One (1) hearing aid per ear every 3 years, up to a maximum benefit of \$1,400 per ear | | One (1) hearing aid per ear every 3 years, up to a maximum benefit of \$1,400 per ear | | One (1) hearing aid per ear every 3 years, up to a maximum benefit of \$1,400 per ear | | One (1) hearing aid per ear every 3 years, up to a maximum benefit of \$1,400 per ear | |

BENEFITS GRID

| Benefit | Commonwealth Essential | | Commonwealth Enhanced | | Commonwealth Premier | | Commonwealth Select | | |
|---|---|----------------------|---|----------------------|---|----------------------|---|----------------------|----------------------|
| | In-network | Out-of-Network | In-network | Out-of-Network | In-network | Out-of-Network | In-network | Out-of-Network | |
| Chiropractor, exam, therapy, manipulations | Deductible then 25%* | Deductible then 50%* | \$10 co-pay | Deductible then 40%* | \$10 co-pay | Deductible then 30%* | Deductible then 10%* | Deductible then 40%* | |
| | Maximum of 26 visits per calendar year, no more than 1 visit per day. | | Maximum of 26 visits per calendar year, no more than 1 visit per day. | | Maximum of 26 visits per calendar year, no more than 1 visit per day. | | Maximum of 26 visits per calendar year, no more than 1 visit per day. | | |
| Durable Medical Equipment (rental up to purchase price) | Deductible then 25%* | Deductible then 50%* | Deductible then 20%* | Deductible then 40%* | Deductible then 10%* | Deductible then 30%* | Deductible then 10%* | Deductible then 40%* | |
| Prescription Drugs | | | | | | | | | |
| Retail Pharmacy thirty (30) day supply | | | | | | | | | |
| | 25% | | | | | | | | |
| | Min | Max | | | | | | | |
| 1 st Tier | \$10 | \$25 | | \$5 | 40% | \$5 | 30% | Deductible then 10%* | Deductible then 40%* |
| 2 nd Tier | \$30 | \$50 | | \$15** | 40% | \$15** | 30% | Deductible then 10%* | Deductible then 40%* |
| 3 rd Tier | \$35 | \$100 | | \$30** | 40% | \$30** | 30% | Deductible then 10%* | Deductible then 40%* |
| Mail Order (ninety (90) day supply | | | | | | | | | |
| | 25% | | | | | | | | |
| | Min | Max | | | | | | | |
| 1 st Tier | \$20 | \$50 | | \$10 | | \$10 | | Deductible then 10%* | |
| 2 nd Tier | \$60 | \$100 | | \$30 | | \$30 | | Deductible then 10%* | |
| 3 rd Tier | \$70 | \$200 | | \$60 | | \$60 | | Deductible then 10%* | |

*Applies to out-of-pocket maximum.

**After the 75th prescription has been filled, excluding mail order, the co-payment will reduce to \$10 2nd tier and \$20 3rd tier.

The Department for Employee Insurance has made every attempt to ensure the accuracy of the benefits outlined in this Benefits Grid. However, if an error has occurred, the benefits outlined in the 2008 Summary Plan Description will determine how benefits are paid.

EXCLUSIONS

THERE ARE SOME MEDICAL EXPENSES THE PLAN DOES NOT COVER. They include, but are not limited to, services or supplies that are not medically necessary and routine procedures not related to the treatment of an injury or illness (except as specifically covered under routine care). Your Summary Plan Description (SPD) will list all of the exclusions and will provide additional details on the exclusions listed below. Some of the expenses that are not covered are:

- Abortion, unless the pregnancy is a life-threatening physical condition of the covered female person;
- Pre-existing conditions to the extent specified on page 30;
- Services, supplies and other care for acupuncture, anesthesia by hypnosis or anesthesia charges for services not covered by the Plan;
- Services, supplies, or other care for cosmetic surgery, and/or complications arising directly from the cosmetic services;
- 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 care;
- Dental services (except as outlined in the SPD) 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);
- Modifications to your home or place of work, such as ramps, air conditioners, seat lift chairs or supplies or attachment for any of these items: professional medical equipment such as blood pressure kits, purchase or rental of escalators or elevators, spas, sauna or swimming pools;
- Any service which is experimental, investigational or for research purposes;
- 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, etc.;
- 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;
- Services provided by a person who ordinarily resides in your home or who is a family member;
- Services not medically necessary for diagnosis and/or treatment of a bodily injury or sickness;

EXCLUSIONS (CONTINUED)

- Physical exams/immunizations (except as otherwise provided) services, supplies, or other care for routine or periodic physical examinations; immunization or tests for screening purposes required by third parties, such as for employment, school, insurance, marriage, adoption, participation in athletics or services conducted for medical research or examinations required by a court;
- Services and/or drugs related to the treatment and/or diagnosis of sexual dysfunction/impotence, including penile implants; and
- Services for the treatment of obesity, except as specifically indicated in the Summary Plan Description.

For additional exclusions, refer to the SPD. The SPD is on the KEHP web site at <http://kehp.ky.gov>.

GENERAL BENEFITS INFORMATION

Pre-existing conditions

A new employee, newly retired person, retiree and/or dependent that was diagnosed or treated during the six (6) months prior to the effective date of this policy will not have coverage for those conditions for the first twelve (12) months. This twelve (12) month pre-existing period will be reduced on a month-by-month basis for any "qualifying prior coverage", such as another employer's health insurance plan, Medicare or Medicaid. However, an employee, retiree, or dependent that has not had coverage during the previous twelve (12) months, or has had a break in coverage of more than sixty-three (63) consecutive days between the prior coverage and enrollment in this Plan, will be subject to the twelve (12) month exclusion.

If the Enrollment Application is submitted within the required timeframes, a pre-existing limitation does not apply to the following conditions:

- pregnancy,
- domestic violence,
- genetic information in the absence of a diagnosis for such a condition,
- newborn children, or children adopted before the age of 18, if they are covered under the Plan within the required timeframes.

Providers

Provider directories are subject to change throughout the year. Although your physician may be participating with Humana as of January 1, that does not guarantee he/she will remain with the Plan throughout the year.

Providers may discontinue participation with Humana at any time during the year. The Personnel Cabinet has contracted with Humana to utilize their Choice Care PPO network of providers. The network is utilized by groups other than the KEHP. **Neither the KEHP, the Personnel Cabinet, nor the Department for Employee Insurance is involved in contract issues between providers and Humana.**

Coordination of Benefits

The KEHP has a coordination of benefits provision which means that if you, or your dependents, are covered by more than one health insurance plan, determination will be made as to which plan will pay primary (first) and which will pay as secondary. The coordination of benefits provision for your dependents is determined as follows:

- If your spouse is covered by another health insurance plan, his/her plan is always the primary plan. Your plan through the KEHP will pay as secondary.
- If your dependent children are covered by another health insurance plan, the primary plan for your dependent children is the parent's

GENERAL BENEFITS INFORMATION (CONTINUED)

plan whose birthday occurs first in the calendar year. If both parents have the same birthday, the plan that has been in force for the longest period of time is the primary plan.

- If there is a court decree which establishes financial responsibility for a dependent child's healthcare expenses, the plan of the parent with that responsibility is primary. Refer to your Summary Plan Description (SPD) for specific information on Coordination of Benefits.

Note:

You must indicate whether you or your dependents have other insurance by completing the information online or by completing Section VII of the Enrollment Application. If information is not provided, Humana will require you to provide information on an annual basis regarding coordination of benefits. The information must be provided **BEFORE** claims are paid.

Deductible

The deductible is the initial amount of medical or hospital expenses you must pay before the Third Party Administrator starts paying benefits.

If you have more than one family member covered under your plan, one has to meet the individual deductible and the remaining family deductible can be met by any combination of the individual family member's claims up

to the family deductible maximum. Here are the deductible rules:

- No single family member has to pay more than the single deductible;
- No single family member can contribute more than the single deductible amount toward the family deductible maximum;
- Of the family maximum deductible, the single deductible amount can be met by a family member and the remaining deductible can be met by a combination of additional family members;
- All family members' services can be combined and applied to meet the family deductible.

PRESCRIPTION DRUG BENEFITS



Express Scripts is the Third Party Administrator that administers the pharmacy benefit for the Kentucky Employees Health Plan. Express Scripts is not a subsidiary of Humana.

The KEHP utilizes the Express Scripts nationwide pharmacy network, which includes most large pharmacy chains and many small independently owned pharmacies. In fact, most pharmacies in Kentucky participate with Express Scripts nationwide network.

The amount you pay for a prescription drug will depend on whether the drug you receive is on the first, second or third tier of the formulary.

Generic drugs

The U.S. Food and Drug Administration (FDA) subjects every generic drug to rigorous testing. If a generic drug doesn't meet the same high standards as the brand name drugs, it is not approved.

Generic drugs are therapeutically equivalent to brand name drugs whose patents have expired. That is, a generic drug has the same chemical makeup as the original brand name drug. Generics account for more than 45% of all medications prescribed in the U.S.

Generics are:

Safe - they have the same active ingredients and are used in the body the same way as their original brand name drugs. They are approved by the FDA, just like brand name drugs.

Effective - they are just as strong and deliver the same medical benefits as the brand name drugs.

Less expensive - they are not advertised like brand names, and they cost less to produce, so the savings are passed on to you in the form of a lower co-pay or coinsurance.

The use of generic drugs saves the KEHP money, which can positively affect your premium contribution. Remember, the KEHP is self-insured and any savings the Plan experiences will save you money.

If a generic drug is available, Kentucky Law requires the pharmacy to dispense the generic drug. If you request the brand name drug, you will pay the brand name co-pay/coinsurance plus the difference in the total cost of the generic and the total cost of the brand name (also referred to as ancillary charges).

Mail order drug benefit

The mail order drug benefit provides a ninety (90) day supply of maintenance drugs for a two-month co-pay or coinsurance. Express Scripts utilizes First Data Bank to determine which drugs are considered maintenance

PRESCRIPTION DRUG BENEFITS (CONTINUED)

drugs. First Data Bank makes this determination based on the drug company's recommended dosage and the Food and Drug Administration.

To qualify for the mail order benefit, the drug must be listed on Express Scripts' maintenance drug list and you must have filled at least one thirty (30) day supply or one ninety (90) day supply within the last 180 days. If you fill a ninety (90) day supply, and for any reason do not refill within 180 days, you will be required to again have one thirty (30) day fill prior to receiving another supply at the reduced co-pay or coinsurance.

The mail order benefit is available two ways - either through Express Scripts mail order program, which delivers your prescription straight to your door or at participating retail pharmacies by simply going to the retail pharmacy to pick up your prescription. For a listing of the local retail pharmacies participating in the mail order program, refer to the KEHP web site or contact Express Scripts.

Home Delivery Education (HDE) Overview

If you are filling a maintenance medication at a retail pharmacy for a thirty (30) day supply, you will receive a letter from Express Scripts informing you of potential savings by filling a ninety (90) day script. Each communication will provide one or more of the following messages based on the number of maintenance medications you are currently taking:

- Personalized Messaging - Letter content may include the name of targeted drugs you have filled at retail and any potential annual savings.
- Express Scripts will call your doctor for you to get a new prescription for the mail order benefit. You are given the option to get started with the mail order benefits either:
 - Online by visiting www.express-scripts/startnow, or
 - Calling the provided dedicated customer service phone number to speak with a Patient Care Advocate
- Self service – you will be instructed how to send a prescription to Express Scripts Home Delivery and you will be provided with a mailer to use to submit your prescription. You may also take that prescription to your local participating pharmacy to receive the benefit.
- Automated Outbound Call – you may receive an automated outbound call with an option to transfer to a Patient Care Advocate offering assistance in getting started with the mail order benefit.

Quantity Level Limits

Quantities of some medications may be limited based on recommendations by the Food and Drug Administration (FDA) and the manufacturer. Limits are in place to ensure safe and effective drug

PRESCRIPTION DRUG BENEFITS (CONTINUED)

use and to guard against overuse of such drugs. Drugs subject to the QLL are indicated on the Formulary Listing. If there is a medical reason that you would need above the QLL, your doctor can call Express Scripts for a prior authorization.

CuraScript Specialty Pharmacy

Express Scripts has partnered with CuraScript to provide certain oral and injectable specialty medicines. These specialty drugs are required to be filled through CuraScript. However, you will be allowed to obtain your first fill of a new prescription at your retail pharmacy. You will then receive a letter from Express Scripts advising that future refills must be handled through CuraScript.

CuraScript is a leading provider of specialty medications, offering many products and services to patients using these medications. Specifically, CuraScript offers:

- A Patient Care Coordinator
- Secure, express delivery of your specialty medications directly to you or your doctor.
- Supplies, such as syringes, swabs, band-aids to administer your medications – at no additional cost.
- Care management programs to help you get the most from your medications.

You may contact CuraScript toll-free at (866) 413-4135 (Monday - Friday 8:00 a.m. - 9:00 p.m., Eastern Standard Time, and Saturday 9:00 a.m. - 1:00

p.m., Eastern Standard Time). A Patient Care Coordinator will contact your physician and work with you to schedule a delivery time for the medication.

Specialty drugs are injectable and non-injectable drugs defined as having one or more of several key characteristics, including:

- Requirement for frequent dosing adjustments and intensive clinical monitoring to decrease the potential for drug toxicity and increase the probability for beneficial treatment outcomes;
- Need for intensive patient training and compliance assistance to facilitate therapeutic goals;
- Limited or exclusive product availability and distribution;
- Specialized product handling and/or administration requirement;

Prior Authorizations

The KEHP requires prior authorization for specific medications. The purpose of prior authorization is to promote clinically appropriate, cost-effective drug therapy using objective clinical criteria. If you take a new prescription to the pharmacy and the pharmacist says it requires prior authorization, ask your physician to call Express Scripts' Prior Authorization line at (800) 241-1390. Your physician must call for the prior authorization.

PRESCRIPTION DRUG BENEFITS (CONTINUED)

Step Therapy

In Step Therapy, the covered drugs you take are organized in a series of “steps” with your doctor approving and writing your prescriptions.

Step Therapy is developed under the guidance and direction of independent, licensed doctors, pharmacists and other medical experts. Together with Express Scripts, they review the most current research on thousands of prescription drugs, and then carefully choose the appropriate medication for the first step.

The program usually starts with generic drugs in the first step. This first step allows you to begin or continue treatment with safe, effective prescription drugs that are also affordable.

Your doctor is consulted, approving and writing your prescriptions based on the list of Step Therapy drugs. For instance, your doctor must write you a new prescription when you change from a second step drug to a first step drug.

If your doctor decides, that for medical reasons, your treatment plan requires a second step medication instead of a first step medication, your doctor can contact Express Scripts to request a prior authorization.

If you are currently taking a medication that requires step therapy, you will not be required to start the step therapy process.

Note

The formulary remains the same throughout the year unless:

- A generic drug becomes available. The brand name will move to the third tier;
- The drug becomes available over-the-counter; or
- The FDA pulls the drug from the market.

Inherited Metabolic Diseases

The KEHP will cover amino acid modified preparations or low-protein modified food products if prescribed for the treatment of certain inherited metabolic diseases, subject to a plan year benefit maximum of \$25,000 for medical formulas and a separate plan year benefit maximum of \$4,000 for low protein modified foods. Benefits are payable at the third tier co-payments/coinsurance. Refer to your Summary Plan Description for more details on this benefit.

PRESCRIPTION DRUG BENEFITS (CONTINUED)

Frequently Asked Questions regarding the prescription drug benefits

Why is it necessary to have a formulary?

With the selection of drugs being so large and varied, a formulary is developed by Express Scripts based on drugs that are safe, effective and economical. This allows the KEHP to continue to offer a low cost prescription drug benefit to our members.

How will members know what drugs are on the formulary?

A formulary is distributed at Benefit Fairs and will be included in member packets. You may also access your prescription drug benefits on Express Scripts web site at www.express-scripts.com or request a copy by calling (877) 597-7474. The formulary is also posted on the KEHP web site at <http://kehp.ky.gov>.

Where can I locate a copy of the formulary?

A formulary can be located on the KEHP web site at <http://kehp.ky.gov>.

How will I know if the formulary changes during the plan year?

If the formulary changes during the plan year, Express Scripts is required to notify, in writing, all members affected by the change, at least thirty (30) days in advance.

Who decides what drugs to include in our Prior Authorization and Step Therapy programs?

The KEHP utilizes Prior Authorization and Step Therapy programs that have been developed under the guidance and direction of independent licensed doctors, pharmacists and other medical experts. Together with Express Scripts, these experts review the most current research on thousands of drugs tested and approved by the FDA as safe and effective. They recommend prescription drugs that are appropriate for Prior Authorizations, Step Therapy and other clinically based prescription drug programs.

What happens if my doctor's request for prior authorization or Step Therapy is denied?

The KEHP has an appeals process for any denial of prescription drugs. Refer to pages 62-65 for additional information regarding appeals.

If I've already tried a first step drug and it does not work, what can I do?

With Step Therapy, second step drugs are covered if:

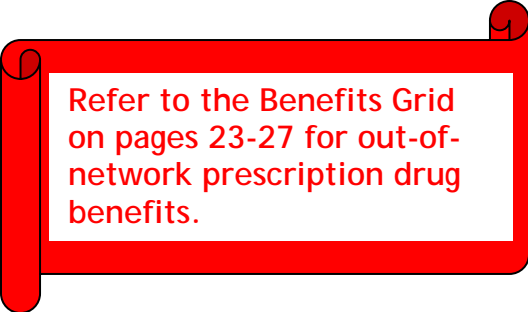
- you've recently tried first step drugs that are covered in the Step Therapy program, or
- your doctor decides you need a second step drug for medical reasons.

PRESCRIPTION DRUG BENEFITS (CONTINUED)

If one of these applies to you, your doctor can contact Express Scripts to request a prior authorization for you to take a second step drug. If the prior authorization is approved, you pay the appropriate co-payment for the drugs, plus any ancillary fees, if applicable.

Are generic medications safe and effective?

Yes. Generic medications have the same chemical makeup and same effect in the body as the original brand name drug. They are equal in quality and effectiveness to their brand name equivalent. Generics have been rigorously tested by the U.S. Food and Drug Administration.



Refer to the Benefits Grid on pages 23-27 for out-of-network prescription drug benefits.

Prescription drug co-pay/coinsurance in-network

Commonwealth Essential

Retail

Benefits will be paid at a 25% *coinsurance* with the following minimum and maximum payments:

1st Tier - \$10 minimum/\$25 maximum

2nd Tier - \$20 minimum/\$50 maximum

3rd Tier - \$35 minimum/\$100 maximum

Mail Order

Benefits will be paid at a 25% *coinsurance* with the following minimum and maximum payments:

1st Tier - \$20 minimum/\$50 maximum

2nd Tier - \$40 minimum/\$100 maximum

3rd Tier - \$70 minimum/\$200 maximum

Commonwealth Enhanced and Commonwealth Premier

Retail

1st Tier - \$5 co-payment

2nd Tier - \$15 co-payment

3rd Tier - \$30 co-payment

Mail Order

1st Tier - \$10 co-payment

2nd Tier - \$30 co-payment

3rd Tier - \$60 co-payment

Commonwealth Select

All tiers subject to deductible and 10% coinsurance

INFORMED CARE MANAGEMENT



INFORMED CARE MANAGEMENT: A PROGRAM FOR PEOPLE WITH CHRONIC CONDITIONS

Informed Care Management (ICM) is the ActiveHealth® Program that actively engages you and your doctor in your healthcare decision making process.

ICM is a unique program for people with chronic conditions. ICM is designed to help you better manage your health and actively work with your doctors to improve your care.

Through ICM you'll have access to a Nurse Care Manager who will act as your personal health coach. He or she will utilize a unique set of data, educational resources and technology to help you understand and manage your conditions. ICM is available for over thirty (30) different conditions.

Over the course of your conversations, your Nurse Care Manager will:

- Review your health information with you;
- Ensure you are receiving all recommended services for your condition;
- Discuss targets and goals related to your conditions;
- Prepare a plan to help you meet your health goals;
- Suggest questions to ask your doctor;
- Give you information about warning signs and symptoms and what you should do if they occur;
- Identify ways for you to stay healthy; and

- Send you follow up letters that summarize your engagement with the nurse and helpful educational materials.

As a member of ICM, your health information is constantly being monitored by the CareEngine® System. Your Nurse Care Manager will ask you questions about your diet, exercise, allergies and over-the-counter medications. This information will be fed back into the CareEngine, compiled with your claims data, and scanned for opportunities for better care or identify potential medical issues. If an opportunity is found for you, your Nurse Care Manager will contact you to discuss the details of the Care Consideration, answer any questions you may have, and suggest questions to ask your doctor.

If you qualify to participate in the program, you will receive an invitation to enroll. You can also contact us at (877) KY-SPIRIT if you feel you might benefit from the program and we will complete an assessment to see if you in fact qualify for participation.

ICM conditions include, but are not limited to:

- Asthma - adult & pediatric
- Chronic Obstructive Pulmonary Disease (COPD)

INFORMED CARE MANAGEMENT (CONTINUED)

- Diabetes - adult & pediatric
- Breast Cancer
- Congestive Heart Failure
- Coronary Artery Disease
- Hypertension
- Low Back Pain
- Cancer

For a complete list of the ICM conditions, you should contact Humana at (877) 597-7474.

Why Weight Kentucky

Excessive weight is the second leading cause of preventable disease in the United States. It is linked to conditions such as heart disease, stroke, diabetes, hypertension, sleep apnea, osteoarthritis and even some forms of cancer.

The KEHP is offering a free program called Why Weight Kentucky that may help you if you suffer from obesity. This program is part of the Informed Care Management (ICM) Program. If you're ready to improve your health, we're ready to help you manage your weight to begin a new, healthier lifestyle.

If you qualify for the Why Weight Kentucky program, you will have access to a dedicated registered nurse called a Nurse Care Manager. Your Nurse Care Manager will ask you questions about any other conditions you may have, any medications you may be taking or treatments you have discussed with your doctor. You will learn about your risk factors, warning signs of your

conditions and how achieving a healthier weight will help.

Your Nurse Care Manager will be there to offer you support and education to help you achieve safe weight loss goals. Over the course of several phone conversations, they will:

- Discuss the causes and risks of excessive weight gain to one's health and the benefits of weight loss;
- Discuss the importance of being physically active and creating a customized exercise and healthy eating program with your doctor;
- Inform you about weight loss resources on the Internet or in your community; and
- Suggest ways to overcome issues that may arise on your road to achieving your health goals.

If you are currently taking prescription weight loss medications, or wish to take them, you must enroll in the Why Weight Kentucky Program in order to continue filling these prescriptions as a covered benefit.

KEHP WELLNESS PROGRAMS

Smoking Cessation Program

The KEHP has partnered with Express Scripts to provide over-the-counter nicotine replacement therapies (NRT) to employees who participate in an approved smoking cessation program.

Who's eligible?

Any smoker who is 18 years old or older and is covered under the KEHP is eligible to participate in the program.

You must actively participate in an approved smoking cessation program and attend all regularly scheduled sessions or work with the Quit Line counselor on a weekly basis.

What do I have to do?

Enroll in a Cooper Clayton program or in the Kentucky Tobacco Quit Line (800) QUITNOW. Additional information on these programs is included on page 41.

Should I contact my doctor before beginning Nicotine Replacement Therapy (NRT)?

Talk to your doctor or pharmacist if you have any questions about using NRT or if you have any pre-existing health conditions.

How much of the NRT product will I receive?

Eligible participants, who continue participating in an approved smoking cessation program, *will receive 12 weeks of over-the-counter NRT*

products each calendar year. The NRT products are not eligible for the mail order benefit.

The amount that you receive will be based on the manufacturer's suggested usage and information provided by your smoking cessation counselor.

How much will it cost me?

You will pay a \$5 co-pay for each two week supply. This will result in a savings to you of approximately \$70 per month.

Who should I contact for additional information regarding the Smoking Cessation Program?

If you have questions regarding eligibility and benefits with this program, you may contact the Department for Employee Insurance Member Services Branch at (888) 581-8834 or (502) 564-6534.

To find out where a Cooper Clayton Program is offered in your area, contact your local health department or the Kentucky Tobacco Quit Line at (800) QUITNOW (800) 784-8669.

Important – You must be enrolled (covered) in the Kentucky Employees Health Plan in order to receive this benefit. You must also continue participating with either the Cooper Clayton Program or the Kentucky Tobacco Quit Line.

KEHP WELLNESS PROGRAMS (CONTINUED)

Kentucky Tobacco Quit Line (800) QUITNOW



What is the Tobacco Quit Line?

The quit line is a free, statewide, telephone-based tobacco cessation resource. The Quit Line offers a one-on-one proactive counseling program for tobacco users who are ready to quit.

Is it effective?

Yes. Multiple scientific reviews have established that proactive telephone counseling through quit lines is an effective cessation method.

What are the hours of operation?

The hours to speak to a live counselor will be 9 a.m. to 9 p.m. Monday through Friday, Eastern Time. Callers after hours will have the option to leave a voice message, and the call will be returned the next business day by a counselor.

Cooper Clayton Smoking Cessation Program

What is Cooper Clayton?

Cooper Clayton is a highly successful smoking cessation program that uses education, skills training and social support. The classes consist of thirteen (13) one hour weekly sessions (1 orientation and 12 classes) followed by relapse prevention.

Is it effective?

Nicotine Replacement Therapy is proven to be most successful when paired with support group programs such as Cooper Clayton. Requiring participation in the program will maximize your chance of success!

Do I have to attend all classes during the thirteen (13) week program?

Yes. Attending the classes demonstrates your commitment to quit smoking. If you do not attend all classes, you will not be eligible to continue to receive the NRT products through the KEHP.

How can I find out where a Cooper Clayton Class is being offered?

Contact your local health department or call the Kentucky Tobacco Quit Line at (800) QUITNOW (800) 784-8669 for help in finding a class.

KEHP WELLNESS PROGRAMS (CONTINUED)

What if a Cooper Clayton class is not being offered in the near future in my county?

You may call the Kentucky Tobacco Quit Line at (800) QUITNOW (800) 784-8669. This is a proactive telephone counseling program in which you work with a personal coach to quit smoking. Call the Department for Employee Insurance, Member Services Branch for additional information regarding this program.

How do I receive the NRT Benefits?

You must take the Cooper Clayton Smoking Cessation voucher to your meetings. Instructions on how to complete the voucher are included in the Smoking Cessation brochure that is located on the web site or you may call the Department for Employee Insurance for a copy of the brochure. The voucher is available on the Personnel Cabinet's web site or by calling the Department for Employee Insurance, Member Services Branch.

Maternity Program

As part of your health plan, you are invited to participate in ActiveHealth's MaterniCheck Program. The MaterniCheck Program is there to help you and your baby stay healthy during this very exciting time.

Personalized Care Plan

A health coach will work with you to help ensure that you and your baby stay healthy throughout your

pregnancy. Your health coach, called a Nurse Care Manager, will ask you questions about your health over the phone. He or she will then give you a plan of care that meets your needs and will work with you to help you reduce the chance of complications.

Support and Education

The Nurse Care Manager is there to guide you during your pregnancy and answer any questions that you may have. You will receive information in the mail to help you learn more about the changes that occur during pregnancy. He or she may review office visits and test results with you, and make suggestions or referrals to other resources.

The Nurse Care Manager will focus on:

- The importance of regular prenatal care
- Education regarding vaccinations, genetic testing and first trimester screening
- Reviewing your medications and educating you regarding medication safety during pregnancy
- Promoting a healthy pregnancy and lifestyle
- Discussing how any previous or current medical conditions may affect your current pregnancy
- Reviewing the nutritional needs of a pregnant woman
- Educating you regarding the important warning signs/symptoms related to pregnancy complications, including preterm labor and pre-eclampsia

KEHP WELLNESS PROGRAMS (CONTINUED)

- Reinforcing the importance of seeking prompt medical attention if warning signs/symptoms occur
- Screening you for and educating you about depression and pregnancy
- Providing you with literature, including the Baby and Me book and literature on breastfeeding and nutrition.

Helping you talk to your doctor(s)

Your Nurse Care Manager will help you prepare questions to discuss with your doctor(s). When necessary, he or she will contact your doctor(s) to ensure that they have all the information they need to provide the best care for you and your baby.

For more information on the Maternity Program, you may contact *ActiveHealth* at 1-877-597-7474.

Preventive Services

The KEHP is committed to the wellness of our members. As such, the following preventive services are covered under your plan. These services are either covered in full or require a co-pay. Refer to the benefits grid for specific details.

Well child care (routine)

Well child care benefits include the following:

- Complete physical examinations;
- Approved immunizations;
- Lab and screening tests.

Adult well care (routine)

Coverage includes:

- Routine exams
- Lab and x-rays in connection with the routine exam
- Routine mammogram
- Routine pap smear
- Prostate Antigen Testing
- Cardiovascular Screening Blood Test
- Colorectal Cancer Screening test
- Bone Mass Measurements
- Glaucoma screening

Note:

Sometimes during the course of a screening procedure (routine wellness or preventive care), abnormalities or problems may be identified that require immediate intervention or additional diagnosis. **If this occurs, and your provider performs additional necessary procedures, the service will be considered diagnostic and/or surgical, rather than screening, depending on the claim for the services submitted by your provider. This may result in a possible difference in your co-pay and/or coinsurance.**

KEHP WELLNESS PROGRAMS (CONTINUED)

Personal Health Assessment (PHA)

The Kentucky Employees Health Plan, in partnership with Humana provides every covered member with the opportunity to complete a PHA that allows them to evaluate their current health status. The PHA is the first step on the path to enhanced health. It is quick, easy and it delivers information you can use right away, at no additional cost to you.

Take the first step

Answer some basic health questions and you will receive a confidential profile tailored for you. Your personal report comes with recommendations for enhancing and maintaining your health that you can share with your doctor.

The information you provide for your PHA generates a personalized report that is strictly confidential. Neither the Commonwealth nor your employer will ever see your individual results. Humana will use this report, along with your medical claims history, to determine if you would benefit from an Informed Care Management Program. Humana will provide the Commonwealth with cumulative summary data from the completed PHAs with no identifying personal information.

Based on your responses to the questions, the PHA can evaluate your risk for medical conditions. It will also provide you with information to discuss

with your physician, as well as web site links to other resources that provide further assistance.

While it only takes about 15 minutes to complete this assessment, the benefits can last a lifetime. Take this opportunity to gauge your health status and learn how to begin your journey toward wellness.

How to take your Personal Health Assessment

Important: Most internet users have turned on the program that will block pop-up windows. In order to take the PHA, you must disable the pop-up blocker. To disable the blocker, open Internet Explorer®, click on "Tools" on the menu bar, then "Pop-up Blocker", then "Turn off Pop-up Blocker". Remember to turn this back on when you have completed the PHA.

- Go to Humana's web site at www.humana.com.
- If you have not registered, click on "Member" box and then click on "Register Now" on the right side of the screen. If you have already registered, enter your User ID and Password and click on "Go".
- In the yellow menu bar, click on "Health Resources".
- Click "Health Assessment" (if you don't have the pop-up blocker turned off, you will not get beyond this step).
- Click "Launch Humana Health Assessment".

KEHP WELLNESS PROGRAMS (CONTINUED)

- Click either “Accept” or “Decline” to indicate you agree or disagree with the terms then click “Next”. If you decline, you will not be able to take the PHA.
- Once you have completed the PHA, you can go back to the PHA start page and print your report

Who can participate in the PHA?

All active employees and non-Medicare retirees and their dependents are eligible to participate in the PHA.

Do I have to participate?

No. However, the PHA is designed to give you the tools and support you need to change your health habits and work toward a healthier lifestyle.

HumanaFirst® Nurse Advice Line

As a KEHP member, you have access to a registered nurse who can provide medical information 24 hours a day, 7 days a week, called HumanaFirst. No matter what time of the day or night, when you need answers to medical questions, or want advice on what kind of medical care to seek, you can call HumanaFirst.

HumanaFirst can be of assistance when, for example:

- You are worried about a family member’s illness.
- You have fallen and you don’t know if you need to go to the hospital.

- Your child has a fever in the middle of the night.

When you call HumanaFirst at (800) 622-9529, a registered nurse will listen to your concerns and help you determine the appropriate course of treatment. HumanaFirst gives you the comfort of knowing that help is always at your fingertips.

- Confidential service.
- A nurse is available 24 hours a day, 7 days a week.
- Toll-free number makes it easy to call anytime, anywhere.
- Avoid the inconvenience of unnecessary and expensive trips to the emergency room. Of course, in an emergency, you should go to your nearest emergency room or dial 911.
- Qualified nurses help you determine treatment based on information formulated by dozens of physicians and nurses, including renowned specialists from around the nation.
- A registered nurse will ask you questions about your symptoms and provide a recommendation about the care appropriate for your situation.

Call the HumanaFirst Nurse Advice line for 24-hour health information, guidance and support at (800) 622-9529.

KEHP WELLNESS PROGRAMS (CONTINUED)

I choose to be healthy

Making deliberate choices

When you do enough of the small things, big results will follow. That's especially true in wellness, where every small choice you make - avoiding the dessert table, taking that walk every day - provides positive steps toward staying healthy.

Many people do not believe that one small choice can lead to another and another. But believe it! You have a powerful ability to change your long-term health with many small but deliberate choices. So say "no" to heart disease, diabetes, cancer and other chronic conditions, and say "yes" to wellness. We can help you do it.

Say "YES" to good health

Saying "yes" to good health takes effort and information. Humana provides members with:

- ✓ Help getting started - Take the Personal Health Assessment - a confidential lifestyle questionnaire - to see where your health is now and what you need to do to improve it. The results just might surprise you. For information on how to take the assessment, refer to page 44.
- ✓ Health coaching - Phone-based health coaching provides a specially trained expert in behavior modification and motivation to work with you on developing a

personalized lifestyle modification plan related to weight management and exercise, smoking cessation, nutrition, stress and back care. Find out more and enroll at *MyHumana* by selecting the health coaching link in the Health Resources section. You can access other health coaching features online, too.

- ✓ A wellness calendar program - A monthly e-mail to your employer contains links to a wellness calendar and supporting articles on prevention and healthy behavior topics.
- ✓ Preventive reminders - We encourage preventive health screenings by sending reminders for routine screening tests or immunizations.
- ✓ Wellness information - Multiple experts are brought together on *MyHumana*, your password-protected personal page on Humana.com to help support your health and wellness goals, such as:
 - Health centers for men, women, seniors and children
 - Condition centers for weight management, nutrition, exercise, stress management, back pain, tobacco cessation and more
 - Library of health topics, diseases, conditions, tests, medications, treatment options and key decision points

KEHP WELLNESS PROGRAMS (CONTINUED)

- Video and audio health library to offer several short health and wellness topics
- Complementary and alternative medicine (CAM) discount program with discounts on massages, acupuncturists and chiropractic services
- Discounts and coupons for health-related retail products and program.

To access these materials, register at www.humana.com and explore MyHumana.

Long-term wellness does not happen automatically; it requires your commitment and belief in yourself.

What can you do?

- Visit *MyHumana* and use all of its tools and resources, including multi-media health information.
- Take the **Personal Health Assessment** and use the results to plan out your health routine.
- Take note of **monthly health resources** your employers will share with you.

Start today. Commit to making educated decisions about your well-being. Choose to be healthy - and let Humana help!

WAIVING COVERAGE AND HEALTH REIMBURSEMENT ACCOUNTS FOR ACTIVE EMPLOYEES ONLY

Waiving health insurance

Active employees who waive their health insurance may enroll in a Health Reimbursement Account (HRA).

Employees who waive must complete the waiver section of the application or enroll online in order to have their employer contribution directed to an HRA.

Note: IRS guidelines state that if you are covered through a Health Savings Account through a spouse or other employment, you are not eligible to participate in a Health Reimbursement Account. Therefore if you waive coverage and elect our Health Reimbursement Account, you will be in violation of federal tax law.

Employer contribution

The employer contribution for active employees waiving coverage is \$175 per month not to exceed \$2,100 per year. Employees, who are hired with an effective date later than January 1, will receive \$175 for each month in which they are eligible for health insurance. For example, if you are hired March 1, you would be eligible for the employer contribution beginning May 1, and would receive \$175 for eight months.

Enrolling in the HRA

If you wish to waive health insurance, you MUST complete the Waiver Section of the Enrollment Application to have

the Commonwealth contribution directed to the HRA. If you enroll online, you must complete the entire enrollment process (see pages 70-77 for additional information regarding online enrollment). If you complete an enrollment application, you must complete Sections I, V and VIII and submit the completed application to your insurance coordinator prior to the end of Open Enrollment.

What is an HRA?

A Health Reimbursement Account is a federally qualified expense account that consists of funds set aside by employers to reimburse employees for qualified medical expenses. An HRA is not an insurance plan.

Frequently Asked Questions about an HRA

Should I obtain copies of itemized statements when I use my HumanaAccess card?

Yes. IRS guidelines require that Humana substantiate charges when the card is used. Sometimes, Humana automatically substantiates charges (i.e. pharmacy charges). However, if Humana is not able to automatically substantiate a charge, Humana will ask you to submit an itemized statement for substantiation. Humana will send three letters requesting this information. If the statement is not submitted, Humana will suspend your HumanaAccess card and you will not be

WAIVING COVERAGE AND HEALTH REIMBURSEMENT ACCOUNTS FOR ACTIVE EMPLOYEES ONLY (CONTINUED)

able to use the card again until the itemized statement is submitted.

What are the differences between an HRA and an FSA?

The main difference between an HRA and an FSA is that any funds remaining in the HRA at the end of the plan year can be rolled over to the next plan year, provided you continue to waive your health insurance and remain as an active employee with the KEHP. Another difference is the HRA is employer funded while the FSA is employee funded.

Can I contribute my own money into an HRA?

No, federal law prohibits you from being able to contribute money to the HRA. However, you can contribute pre-tax money to a Healthcare FSA to help offset any medical expenses you may have.

If I elect health insurance now, and later experience a QE that will allow me to drop my health insurance, will I be able to elect an HRA and receive the \$175 employer contribution?

No. If you have existing health insurance coverage, and later experience a Qualifying Event to drop your health insurance, you will not be permitted to direct the employer contribution into an HRA. All elections must be made prior to the beginning of

the Plan Year in order to direct the funds into an HRA. If you are a new employee entering in the middle of the plan year, refer to page 48.

If I have an HRA and contribute funds to an FSA, which pays first?

If you contribute funds to an FSA, the FSA funds will always pay first.

Who is eligible to enroll?

Only active employees who are eligible for state-sponsored health insurance coverage may participate in the HRA. Retirees who return to work and are enrolled in the KEHP plan through their retirement system, KRS or KTRS retirees and spouses of hazardous duty retirees are not eligible to participate in the HRA if they waive their coverage.

Can my HRA funds be used to pay for medical expenses incurred by my dependents?

Yes. Eligible dependents include:

- your legal spouse;
- your qualifying child; and
- your qualifying relative.

Is enrollment automatic?

No. Enrollment is not automatic. You must enroll or re-enroll every year. You may enroll in an HRA online or by completing Sections I, V and VIII of the application.

WAIVING COVERAGE AND HEALTH REIMBURSEMENT ACCOUNTS FOR ACTIVE EMPLOYEES ONLY (CONTINUED)

When does coverage begin?

If you enroll during Open Enrollment coverage begins January 1, 2008.

For new employees coverage begins on the first day of the second month following the date of hire. If you do not enroll during your initial eligibility period, you must wait until the next annual Open Enrollment or until you experience a Qualifying Event that would allow you to enroll.

How do I access my HRA funds?

Once your coverage begins, you will receive the free HumanaAccess card in the mail. You can use this card to pay for eligible healthcare expenses at provider locations where Visa cards are accepted. When you use the card, eligible charges are automatically deducted from your HRA fund. If you receive a medical bill with a "Patient Balance Due", write the card number on the provider's bill and return it. The card typically eliminates the need to submit claim forms and wait for reimbursement.

When will I receive my HumanaAccess card?

You will receive your card prior to the effective date of coverage if you enroll during Open Enrollment. Otherwise, you should receive your card within two weeks of your enrollment.

Do I need to activate the HumanaAccess Card?

Yes. Activate your card as soon as you receive it. You can use your card immediately after activation (after your effective date of coverage). To activate the card, you can call (888) 894-2201 and follow the instructions enclosed with the card. (If you receive two or more cards, you need to activate only one for all of them to work).

You should protect your card as you do any other debit card as it can be used by anyone after the card is activated. If your card is stolen or misplaced, contact Humana immediately.

Do I have to use the HumanaAccess card to receive reimbursement for medical expenses?

No. You may submit your itemized bills to Humana by completing the Health Reimbursement Account and Flexible Spending Account Claim Form located on our web site at <http://kehp.ky.gov>. Once completed, submit the claim form along with your itemized receipt and/or Explanation of Benefits (EOB) to Humana.

If I waive my health insurance and have the HumanaAccess card, can I use it at the drug store to purchase prescription drugs?

Yes, you can.

KENTUCKY EMPLOYEES HEALTH PLAN PY 2008

INSURANCE COORDINATOR SECTION

ENROLLMENT APPLICATION FOR ACTIVE EMPLOYEES

| | | | | | | | | | |
|----------------------------------|---|----------------------|---|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|
| <input type="text"/> | / | <input type="text"/> | / | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Coverage Effective Date | | | | | Company Number | | | | |
| <input type="text"/> | / | <input type="text"/> | / | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Deduction Start Date (BOEs ONLY) | | | | | | | | | |

Reason for Application:

- < New Employee
 < Open Enrollment
 < New Group
 < FSA Only
 < QE*
 < Previously Waived*
 < Other*

* If you previously waived, or marked "Other" or "QE" above, enter the Qualifying Event _____
 date AND a description of the Qualifying Event: _____ Date _____ Qualifying Event Description _____

SECTION I: DEMOGRAPHIC INFORMATION → Please PRINT

- -
 Social Security Number Date of Birth (MM/DD/YYYY)

Smoking Status (Required)

Have you smoked in the last 2 months? < Yes < No

NAME (First, MI, Last) _____

Mailing Address _____

City, State, Zip Code _____ County of Residence _____

Planholder's HOME Phone Number _____ Planholder's WORK Phone Number _____ Planholder's Email Address _____

Hire Date _____ Employer Name _____ Work County _____

SECTION II: PLAN SELECTION → If you wish to waive coverage, skip to Section V below

| | | |
|---|--|---|
| 1. Option (Check only one) <input type="checkbox"/> < Commonwealth Essential <input type="checkbox"/> < Commonwealth Enhanced <input type="checkbox"/> < Commonwealth Premier <input type="checkbox"/> < Commonwealth Select | 2. Level of Coverage <input type="checkbox"/> < Single <input type="checkbox"/> < Parent Plus <input type="checkbox"/> < Couple <input type="checkbox"/> < Family | 3. Cross-Reference Payment Option (Available for Family Coverage Only) <input type="checkbox"/> < Yes If Yes, you must complete Sections III and IV |
|---|--|---|

SECTION III: SPOUSE AND/OR DEPENDENT INFORMATION → If you selected Single coverage, skip to Section VI

| Social Security Number | Name (First, MI, Last) | Gender (Circle one) | Date of Birth (MM/DD/YYYY) | Relationship Code |
|------------------------|---------------------------|------------------------|-------------------------------|----------------------|
| | | M F | | |
| | | M F | | |
| | | M F | | |
| | | M F | | |
| | | M F | | |

SECTION IV: CROSS-REFERENCE INFORMATION → Complete ONLY if you checked Yes in Section II, box 3

| | | | | |
|---|---|--|--|--|
| Your Spouse's Company Number: (Required) _____ | Has your spouse smoked in the last 2 months? (Required) <input type="checkbox"/> <Yes <input type="checkbox"/> <No | Is your spouse a Hazardous Duty Retiree? <input type="checkbox"/> <Yes <input type="checkbox"/> <No | Your spouse's Hire Date or Retirement Date: _____ | Your spouse's Deduction Start Date (If BOE employee): _____ |
|---|---|--|--|--|

SECTION V: WAIVER → Complete this section only if you did not select coverage in Section II

Do you wish to waive your coverage and have the employer contribution of \$175 per month deposited into a Health Reimbursement Account (HRA), **if eligible?** (If not eligible, you will be set up as a **Waiver with no HRA**) < Yes

KENTUCKY EMPLOYEES HEALTH PLAN

ENROLLMENT APPLICATION FOR ACTIVE EMPLOYEES

PAGE 1 Instructions

Reason for Application

- **New Employee:** Check this box if you are a new employee.
- **Open Enrollment:** Check this box if you are filling out this application for Open Enrollment.
- **New Group:** Check this box if your employer is joining the Kentucky Employees Health Plan (KEHP) for the first time.
- **FSA Only:** Check this box if you are enrolling in a Flexible Spending Account for the first time due to a Qualifying Event (QE).
- **QE:** Check this box if you are making a change to your overage Option, as permitted by a valid QE.
- **Previously Waived:** Check this box if you previously waived your health insurance coverage and have now experienced a QE that allows you to select coverage. You must provide the date and description of the qualifying event in the spaces provided below. All other QEs do not require an application and do require a Dependent Add or Drop form only. You may request a Dependent Add or Drop form from your Insurance Coordinator (IC) or you may visit www.kehp.ky.gov to print one and must provide supporting documentation, as required.
- **Other:** Check this box if none of the listed options apply. The IC must provide a date and an explanation if "Other" is selected.

TO THE INSURANCE COORDINATOR: Complete the information requested within the box in the top right corner of the application.

For ALL employees - Enter the effective date of coverage and the employee's company number.

For BOE employees only – Enter the Deduction Start Date.

SECTION I: DEMOGRAPHIC INFORMATION – Please PRINT clearly.

- Enter the planholder's Social Security Number, Date of Birth, Name (First, MI, Last), Address (including County of Residence), Smoking Status, Gender, Marital Status, Planholder's HOME and WORK Phone Numbers, Planholder's Email Address, if available, Hire Date, Employer's Name and Work County. **Note:** If the smoking status flag is not checked, this application will be on Pended status until the information is provided. **The smoking status that you select during Open Enrollment or as a new employee will remain for the entire Plan Year. A change in your smoking status is NOT a qualifying event.**

SECTION II: PLAN SELECTION

1. **Option:** Mark the option you are selecting. For a description of each option, see the KEHP Handbook. Select only one.
2. **Level of Coverage:** Mark the level of coverage you are selecting. For a description of each level of coverage, see the KEHP Handbook. Select only one.
3. **Cross-reference Payment Option:** If you wish to elect the cross-reference payment option, check Yes and complete Sections III and IV. This payment option is only available for Family coverage. ONLY ONE application is required.

SECTION III: SPOUSE AND/OR DEPENDENT INFORMATION

Provide the information requested for every dependent you are enrolling (including your spouse if electing the cross-reference payment option). If you need additional space, use Page 1 of another enrollment application.

Relationship Code: Enter the appropriate relationship code as follows:

- SP Spouse (your eligible spouse under a legal marriage).
- CH Child (your eligible child, step child, adopted child, foster child or your grandchild) age 0 to 23 (to enroll, a dependent must be age 23 or less and not turn 24 during the coverage year). See the KEHP Handbook for eligibility requirements and needed supporting documentation to enroll your eligible dependent children (e.i., legal guardianship is required to enroll a grandchild, etc.)
- DD Disabled, Dependent Child (your eligible disabled child). If your disabled dependent child is 24 years old or older, the TPA will request evidence of his/her disability annually.
- CO Court Ordered Dependent Child (an eligible dependent child that you are court ordered to carry on your health insurance).

SECTION IV: SPOUSE'S CROSS-REFERENCE INFORMATION

Complete this section ONLY if you and your spouse are selecting the cross-reference payment option. Enter your spouse's company Number (required), smoking status (required), hazardous duty retiree indicator, hire date or retirement date (if applicable), and the deduction start date (only needed if the planholder elects to start a cross-reference payment option with a school board employee).

SECTION V: WAIVER

Complete this section ONLY IF YOU DID NOT SELECT COVERAGE in Section II. You must mark Yes if you are electing to waive health coverage for the Plan Year and direct the employer contribution of \$175 per month into an HRA, if eligible.

If you do not mark Yes in this section, you will not receive the employer contribution of \$175 per month for the Plan Year. If you are not eligible to receive the employer contribution toward an HRA, you will be set up as a Waiver with NO HRA.

| | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|
| | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|

Planholder's SSN

SECTION VI: FLEXIBLE SPENDING ACCOUNTS (FSA) → Enrollment in an FSA is **OPTIONAL**

If you are an employee of a health department or certain quasi agencies, this section **does not apply to you**. You must contact your insurance coordinator regarding your employer's FSA enrollment process.

Healthcare → All amounts must be divisible by two.

The **minimum** allowable monthly contribution is \$10

The **maximum** allowable yearly contribution is \$5,000

| | |
|---|---|
| <p>Planholder</p> <p>Total Employee Contribution for Plan Year _____</p> | <p>Spouse → If paying by cross-reference and spouse's FSA program is administered by the KEHP</p> <p>Total Spouse Contribution for Plan Year _____</p> |
|---|---|

Dependent Care → All amounts must be divisible by two.

Minimum allowable monthly contribution - \$10

Maximum allowable yearly contribution – based on tax filing status

Tax Filing Status:

< Married, filing separately (max = \$2,500)
 < Married, filing jointly (max = \$5,000)
 < Single, head of household (max = \$5,000)

| | |
|---|---|
| <p>Planholder</p> <p>Total Employee Contribution for Plan Year _____</p> | <p>Spouse → If paying by cross-reference and spouse's FSA program is administered by the KEHP</p> <p>Total Spouse Contribution for Plan Year _____</p> |
|---|---|

HumanaAccessSM VISA® Card

Upon enrolling in an HRA or an FSA, you will receive the HumanaAccessSM Visa® card at no cost to you.

SECTION VII: COORDINATION OF BENEFITS

Are you or any of your dependents listed on this application covered under another health insurance plan? < Yes < No

SECTION VIII: AUTHORIZATION AND CERTIFICATION

- * I understand that my signature on this application creates a legal and binding contract between myself, the Department for Employee Insurance and the TPA.
- * I understand that if my spouse and I elect the cross-reference payment option, our level of coverage (Family) cannot change if one of us terminates employment, and the remaining spouse will pay the full family contribution.
- * I understand that each dependent I am enrolling meets the eligibility requirements of a dependent as set forth in the plan document and in the KEHP handbook.
- * I understand that all benefits for my eligible dependents and me will be provided in accordance with the plan document.
- * I agree to abide by the terms and conditions governing membership and receipt of services from the plan in which I have enrolled.
- * I understand that the elections indicated on this application may not be changed or canceled during the plan year, with the exception of certain Qualifying Events.
- * I authorize my employer to deduct from my earnings the amount required to cover my share of the coverage I have selected.
- * I elect to have the employee contribution for health coverage deducted on a pre-tax basis unless I sign a Post-Tax Request form.
- * I understand that enrollment in an FSA is optional and that by completing Section VI of this application, I am enrolling in an FSA, if eligible to participate.
- * Regarding my FSA, I understand that any dependents for which I claim reimbursement are Section 152 dependents as defined by the Internal Revenue Code.
- * Regarding my FSA, I further understand that any unused amount remaining in my spending account at the end of the plan year cannot be carried forward to the next year due to the Commonwealth's Cafeteria Plan Document.
- * I understand that I have a 90-day run-out period (until March 31) for reimbursement of eligible FSA expenses incurred during my period of coverage.
- * I understand that the misrepresentation of any information on this application with the intent to defraud is a fraudulent insurance act, which is a crime, and any material misrepresentation or omission may be used to reduce or deny a claim or to terminate my coverage.
- * I have fully read the materials provided to me. My signature below certifies that the statements on this form are true and complete to the best of my knowledge.

Employee Signature

Date

Spouse Signature – **REQUIRED if electing the cross-reference payment option**

Date

.....
I understand that any person who knowingly, and with the intent to defraud any insurance company or other person, files an application for insurance containing any forged signature or incorrect signature date thereto commits a fraudulent insurance act, which is a crime. I understand that I can be held responsible for any fraudulent act that is the result of a forged signature or incorrect signature date that I could have prevented while acting within my duties related to the KEHP. My signature below certifies that all signatures and signature dates affixed to this contract are correct to the best of my knowledge.

Employee's Insurance Coordinator Signature

Date

Spouse's Insurance Coordinator Signature – **REQUIRED if electing the cross-reference pmt. option**

Date

KENTUCKY EMPLOYEES HEALTH PLAN

ENROLLMENT APPLICATION FOR ACTIVE EMPLOYEES

PAGE 2 Instructions

Enter the social security number of the planholder in the spaces provided on the top right hand corner of Page 2.

SECTION VI: FLEXIBLE SPENDING ACCOUNTS (FSA)

- This section can only be completed by employees of state agencies, boards of education and certain quasi agencies.
- If you are an employee of a health department or certain quasi agencies, you cannot use this section to enroll in an FSA. You must contact your IC regarding your employer's FSA enrollment process and deadlines.
- Enrollment in an FSA is OPTIONAL and is completely funded from employee's funds (no employer funds are directed into an FSA). In order to direct an amount into an FSA you must enroll, either online or by completing this section (for state, board of education and certain quasi agency employees) by the deadline.
- All amounts entered in this section are yearly amounts.

Healthcare

All amounts must be divisible by two.

PLANHOLDER

Total Employee Contribution for Plan Year: Enter the total employee contribution amount for the entire coverage period.

SPOUSE (For cross-reference payment option only)

Complete this section with YOUR SPOUSE'S Healthcare FSA information, only if your spouse meets ALL of the following:

- He/she is a state employee, a board of education employee, or a quasi agency employee for whom the KEHP administers the FSA program;
- He/she is electing the cross-reference payment option; and
- He/she is electing to enroll in the available FSA program. Enrollment in a Flexible Spending Account is OPTIONAL.

Total Spouse Contribution for Plan Year: Enter the spouse's total contribution amount for the entire coverage period.

Dependent Care

Mark the tax filing status that applies to you (or to both of you if your spouse is eligible and is also enrolling).

PLANHOLDER

Total Employee Contribution for Plan Year: Enter the total employee contribution amount for the entire coverage period.

SPOUSE (For cross-reference payment option only)

Total Spouse Contribution for Plan Year: Enter the total contribution amount for the entire coverage period.

HumanaAccessSM VISA[®] Card: If you are eligible and elect to participate in an employer-funded HRA (for waivers or for employees selecting the Commonwealth Select Plan) or in an employee-funded FSA Program (for state agencies, boards of education and certain quasi agency employees), you will receive the HumanaAccessSM VISA[®] card at no cost to you. This is a free service offered to you.

SECTION VII: COORDINATION OF BENEFITS

Check whether or not you, or any of the dependents listed on this application, are covered under another health insurance plan.

SECTION VIII: AUTHORIZATION AND CERTIFICATION

- **Read each statement carefully.** After you have read and understood the statements, sign your name and enter today's date in the lines provided. If you are electing the cross-reference payment option, your spouse MUST also sign and date the application.
- Your cross-referenced spouse must have his/her insurance coordinator(IC) sign this form before you return it to your IC.
- Your cross-reference application will not be processed without the four required signatures and dates.

REMEMBER THAT YOU HAVE THE OPTION TO ENROLL ONLINE at www.kehp.ky.gov. ENROLLING ONLINE IS EASY, FAST AND SECURE. IF YOU ENROLL ONLINE, YOU WILL RECEIVE INSTANT CONFIRMATION THAT YOU HAVE ENROLLED! **PRINT AND SAVE YOUR CONFIRMATION PAGE!**

WAIVING COVERAGE AND HEALTH REIMBURSEMENT ACCOUNTS FOR ACTIVE EMPLOYEES ONLY (CONTINUED)

Here are the steps to take when paying at the pharmacy:

- Select a pharmacy that participates in Humana's Spending Account Secondary Payer Pharmacy Network. To find a complete list of the participating pharmacies, visit kyhealthplan.humana.com.
- When you pick up your prescription, present your primary insurance card so your pharmacist can identify your co-pay amount and bill your insurer.
- Ask your pharmacist to follow the instructions on the card to submit a second claim to Humana, which takes only a few moments.
- Then, present your HumanaAccess card for payment or swipe it through the credit card machine.
- Select "credit" - not "debit" - for your transaction.
- Sign and save your receipt.

COMMONWEALTH CHOICE FLEXIBLE SPENDING ACCOUNTS (FSAs)

Active state employees, local school board employees and certain quasi agency employees are eligible to participate in the Flexible Spending Accounts administered by the Department for Employee Insurance (IRS regulations do not allow retirees to participate in an FSA). There are two types of FSA accounts available - a **Healthcare FSA** and a **Dependent Care FSA**. The FSA accounts are offered under a Section 125 cafeteria plan and therefore, contributions are made on a pre-tax basis, which saves you money.

Healthcare FSA

A Healthcare FSA is pre-tax money you set aside, through payroll deductions, to use for certain expenses not reimbursed by your medical plan. You decide how much to contribute to your Healthcare FSA. You may contribute specified amounts and use the funds to pay toward out-of-pocket prescription costs and eligible medical expenses

such as doctor's office visits, x-rays, and lab tests; and some services not covered by your health insurance plan.

Frequently Asked Questions regarding the Healthcare Flexible Spending Account

Who is eligible to enroll in an FSA?

If you are an employee of a state agency or school board you are eligible for participation in the Commonwealth Choice Flexible Spending Account Program.

If you are an employee of a local health department or a quasi governmental agency, you must contact your Insurance Coordinator for details.

How does it save me money?

A healthcare FSA is a pre-tax benefit. Let's look at an example:

| | No FSA | With FSA |
|--|----------|--------------|
| Annual Taxable Income | \$28,000 | \$28,000 |
| Pre-tax money deposited into FSA through payroll deduction. | 0 | \$1,500 |
| Remaining taxable income | \$28,000 | \$26,500 |
| Minus federal and Social Security taxes | \$9,982 | \$9,447 |
| Remaining take-home pay | \$18,018 | \$17,053 |
| Minus the take home pay spent on qualified expenses | \$1,500 | 0 |
| Remaining take home pay | \$16,518 | \$17,053 |
| Savings | 0 | \$535 |
| This example is intended to demonstrate a typical tax savings based on 28% federal and 7.65% FICA taxes. Actual savings will vary based on your individual tax situation. Consult a tax professional for more information on tax implications of an FSA. | | |

COMMONWEALTH CHOICE FLEXIBLE SPENDING ACCOUNTS (FSAs) (CONTINUED)

What are the minimum and maximum contribution amounts?

The minimum contribution is **\$10 per month** and the **maximum contribution for the Healthcare FSA is \$5,000 per year**.

Are over-the-counter expenses covered under my healthcare FSA?

Yes. Eligible over-the-counter expenses can be reimbursed through the Healthcare FSA. Refer to the KEHP web site (<http://kehp.ky.gov>) for a listing of eligible over-the counter expenses.

Can I enroll later if I don't enroll at Open Enrollment or upon hire?

If you do not enroll when first eligible, you may be able to change your initial election and make a new election mid-year if you experience an eligible Qualifying Event. Contact your Insurance Coordinator or the Department for Employee Insurance for specific requirements and limitations on Qualifying Events for the FSA program.

What expenses are eligible?

A few examples of eligible covered expenses are listed below. You can see the complete listing at <http://kehp.ky.gov>.

- Covered over-the-counter expenses such as, but not limited to,

peroxide, aspirin and allergy medication

- Dental fees
- Orthodontic treatment
- Vision fees, including eyeglasses
- Doctor's fees
- Prescription co-payments or coinsurance
- Wheelchairs
- Guide dogs

How do I get reimbursed for covered expenses?

The easiest way to get reimbursed is by swiping the HumanaAccess card at the point of service! You can only get reimbursed for claims incurred during your coverage period.

Once your coverage begins, you will receive the free HumanaAccess card in the mail. You can use this card for healthcare FSA eligible expenses wherever Visa debit cards are accepted, such as participating pharmacies, doctor's offices, and hospitals. When you use the card at the pharmacy, eligible charges are automatically deducted from your FSA fund. You can even present your HumanaAccess card for payment at the time services are rendered at your doctor's office. If you receive a medical bill with a "Patient Balance Due", write the card number on the provider's bill and return it. The card usually eliminates the need to submit claim forms and wait for reimbursement.

COMMONWEALTH CHOICE FLEXIBLE SPENDING ACCOUNTS (FSAs) (CONTINUED)

Refer to pages 60-61 in this Handbook for more information on the HumanaAccess card.

You can also pay for your services up front and submit copies of your claims and a completed claim form (which can be found at <http://keh.ky.gov>) to:

Humana Spending Account
Administration
P. O. Box 3967
Louisville, KY 40201-3967

Is there a time limit for submitting claims?

Yes, all claims incurred during your coverage period must be submitted for reimbursement by March 31st of the following year. This applies if you are covered the full Plan Year (January 1 - December 31) or if your coverage terminates during the year.

When does coverage begin?

If you enroll during Open Enrollment your coverage begins January 1, 2008.

If you are a new employee, your coverage begins on the first day of the second month following your date of hire.

If you do not enroll online or by completing an Enrollment Application during your initial eligibility period, you must wait until the next annual Open Enrollment or until you experience a Qualifying Event that would allow you to enroll.

Dependent Care FSA

A Dependent Care FSA is pre-tax money you set aside, through payroll deductions, to use for certain dependent care expenses, such as day care, after school child care programs and summer day camps.

When does coverage end?

The FSA terminates at the end of the Plan Year, which is December 31, 2008, unless you have a Qualifying Event that causes your coverage to terminate earlier.

Frequently Asked Questions regarding the Dependent Care Flexible Spending Account

Who is eligible?

If you are an employee of a state agency or school board you are eligible for participation in the Commonwealth Choice Flexible Spending Account Program.

If you are an employee of a local health department or a quasi governmental agency, you must contact your Insurance Coordinator for details.

How does it save me money?

A dependent care FSA is a pre-tax benefit so it reduces federal and state income taxes.

COMMONWEALTH CHOICE FLEXIBLE SPENDING ACCOUNTS (FSAs) (CONTINUED)

What are the minimum and maximum contribution amounts?

The minimum contribution amount is \$10 a month and the maximum annual contribution amount depends on your tax filing status as listed below:

Married filing jointly - \$5,000
Married filing separately - \$2,500
Single and head of household - \$5,000

If either you or your spouse earns less than \$5,000 a year, your maximum annual contribution is equal to the lower of the two incomes. If your spouse is a full-time student or incapable of self care, your maximum annual contribution is \$3,000 for one dependent and \$5,000 for two or more dependents.

How long do I have to submit my expenses for a Dependent Care FSA?

All Dependent Care FSA expenses must be incurred prior to the end of the plan year (or termination date of the Dependent Care FSA) and must be filed for reimbursement by March 31 of the following calendar year.

How will I get reimbursed?

Dependent Care FSA funds will be deducted from each paycheck automatically, beginning with the first paycheck after the effective date of your coverage. After you pay eligible dependent care expenses, save your receipts to file a claim for

reimbursement. To file a claim for reimbursement:

- Log onto MyHumana, go to the MyBenefits section and select your "Dependent Care FSA" from the drop-down box
- Go to "File a Claim"
- Double click on the reimbursement form, print it, fill it out and mail it with your receipts to:

Humana Spending Account
Administration
P. O. Box 3967
Louisville, KY 40201-3967
(800) 604-6228

If you do not have Internet access, you may call Humana's customer service to request a claim form.

You may only use funds already in your account to pay for eligible dependent care expenses.

Note: The HumanaAccess card is not available for use with the Dependent Care FSA.

HUMANACCESSSM VISA[®] CARD



You will receive a HumanaAccess card if:

- You waive your health insurance, elect to receive and are eligible for an HRA;
- You enroll in the Commonwealth Select Plan; or
- You enroll in a Healthcare Flexible Spending Account (FSA)

Activate it

When you receive your card, call (888) 894-2201 toll-free to activate it. If you receive more than one card, you only need to activate one for both to work.

Pay for other healthcare services

Pay your doctor visit co-pays with your HumanaAccess card. If you don't have a co-pay, wait until you receive a bill in the mail, write the card number on the bill and return it, or simply call the doctor's office and provide your card number and expiration date.

Use your HumanaAccess card to pay for any eligible healthcare expenses, such as:

- Co-pays, coinsurance, and deductibles
- Hospital charges
- Medical supplies
- Urgent care and emergency room visits

Note: You cannot use your HumanaAccess card for:

- Over-the-counter expenses
- Dependent Care FSA expenses

Manage your balance

For your card transaction to go through, you must have enough funds in your account to cover the full amount of the charges. To see your current balance and account activity:

- Go to www.myhumana.com
- Then click on "Register Today" if you haven't registered previously; otherwise, sign in using the User ID and password previously created on the member page
- You will then be at the MyHumana home page
- Under the MyBenefits heading, click on Healthcare FSA, and then click on "MyAccount" to see your HAC balance

You can also check your balance by calling (800) 604-6228.

HUMANAACCESS VISA CARD (CONTINUED)

Frequently Asked Questions regarding the HumanaAccess card

Do I need to save my statements from the providers when I use my HumanaAccess card?

Yes. IRS regulations require that Humana substantiate all reimbursements made with the HumanaAccess card. If Humana is not able to substantiate the expense through its claims system automatically, you will be requested to submit the necessary paperwork to substantiate those reimbursements.

What happens if I do not send in the receipt that Humana requests?

Humana may contact you through a letter requesting a receipt or Explanation of Benefits to verify that you used your card only for qualified expenses.

If, after three attempts to contact you for substantiation, you fail to provide the required documentation, your HumanaAccess card will be deactivated and no more purchases will be able to be made using the card. However, as soon as you submit the proper documentation to substantiate your claims, your HumanaAccess card will be reactivated.

If your submitted documentation fails to show that the HumanaAccess card was used for an eligible covered expense, the IRS requires that you repay the expense.

How do I request reimbursement for an overpayment I made to my doctor using my HumanaAccess card?

If you overpay your doctor with your HumanaAccess card, the doctor should return the overpaid amount to your spending account. Ask the doctor's staff to credit your card. If the doctor sends you a reimbursement check instead of crediting your account you will be required to reimburse the KEHP.

If I enroll in an HRA and an FSA account, how many HumanaAccess cards will I receive?

For your convenience, Humana will send you two HumanaAccess cards in the mail. However, each card will give you access to both of your funds.

MEDICAL CLAIMS APPEALS

Note: The Appeals procedures described below are only for medical and prescription drug concerns. Refer to page 93 if you would like to file a grievance regarding eligibility or enrollment.

Appeals

If your medical claim or prescription has been denied, you have the right to file an appeal to Humana or Express Scripts, respectively. The following section outlines your rights to file an appeal.

1. **Adverse Determination** means when the Plan determines that procedures performed or proposed to be performed are not medically necessary or are considered experimental or investigational and therefore are denied, reduced or terminated. An Adverse Determination does not mean a determination that the healthcare services are not covered.
2. **Coverage Denial** means services, treatments, drugs or devices that are specifically limited or excluded under the covered person's plan.
3. **Administrative Appeals** is for situations that do not fall in the category of either adverse determinations or coverage denials. For example, a member feels his/her cost should be reduced from what is

determined by the plan (i.e., a drug is covered on the 3rd tier and the member feels the drug should be covered as a first or second tier co-pay).

Who performs the appeal?

Adverse Determination - The Third Party Administrator will handle the Internal Appeal Process for Adverse Determinations in accordance with KRS 304.17A.600-633.

Coverage Denial - The Third Party Administrator will handle the Internal Appeal Process for Coverage Denials in accordance with KRS 304.17A.600-633.

Administrative Appeals - The Department for Employee Insurance will handle all Administrative Appeals.

How to file an Internal Appeal - Adverse Determination or Coverage Denial

To appeal a denial of a *hospital, physician or other provider's services*, the member, authorized person or provider should file an appeal to:

MEDICAL CLAIMS APPEALS (CONTINUED)

Humana
Grievance and Appeals
P.O. Box 14546
Lexington, KY 40512-4546

To appeal a denial of a *prescription drug*, the member, authorized person or provider should file an appeal to:

Express Scripts, Inc.
Appeals - CKY
Mail Route BLO390
6625 W. 78th Street
Bloomington, MN 55439

Initial Complaint - a member should always contact the Third Party Administrator's Customer Service Department first (the number is located on the back of the ID card). Many problems can be resolved the same day. If not, the member services representative will investigate and contact the member with their findings and any action taken to resolve the complaint. If a member's complaint is related to a denial of coverage or other decision by the Third Party Administrator, the member may file an appeal.

Internal Appeal - If the complaint is not resolved to the satisfaction of the member, on the initial complaint to the Third Party Administrator's Customer Service Department, the employee may request an internal appeal. A request for an internal appeal must be submitted in writing within 180 days of receipt of a denial letter. The letter should be sent to the address listed above and should include at a minimum the following information:

- Member's name and patient's name.
- The member's Kentucky Employees Health Plan Identification Number (found on the member's health insurance card).
- The member's address and daytime phone number.
- The initial denial letter.
- The service being denied. Include all facts and issues related to the denial, including the names of providers involved and medical records.

Note: A physician who did not participate in the initial review and denial will review the internal appeal. If the Denial is for an Adverse Determination and the service requires a medical or surgical specialty, you may request a review by a board eligible or certified physician from the appropriate specialty.

The Third Party Administrator will notify the member of the internal appeal decision within thirty (30) calendar days of receipt of the internal appeal request.

Expedited Appeal - An expedited appeal is deemed necessary when a covered person is hospitalized or, in the opinion of the treating provider, review under the normal timeframe could, in the absence of immediate treatment result in any of the following:

- Placing the health of the covered person or, with respect to a pregnant woman, the health of the

MEDICAL CLAIMS APPEALS (CONTINUED)

covered person or the unborn child in serious jeopardy;

- Serious impairment of bodily functions; or
- Serious dysfunction of a bodily organ or part.

The Third Party Administrator shall render a decision within three (3) business days of receipt of the request for an expedited appeal. The expedited appeal may be requested orally with a follow-up letter.

At anytime during the internal appeal, additional pertinent information may be submitted for consideration.

How to file an External Appeal- Adverse Determination

Before a member can request an external appeal, they must exhaust their rights to an internal appeal. The internal appeals process can be waived if both the member and the Third Party Administrator agree.

Adverse Determinations - If the member is not satisfied with the decision of the internal appeal regarding an adverse determination, the member may request an external appeal. The external appeal will be handled by an independent review entity (IRE) that is certified by the Kentucky Office of Insurance.

The external appeal must be requested by the member, authorized person or provider acting on behalf of and with the consent of the member within sixty (60) days after receipt of the internal

appeal decision letter. The member must have completed the internal appeal process, or the Third Party Administrator must have failed to make a timely determination or notification. In addition, the member must have been eligible and enrolled on the date of service and eligible to receive covered benefits under the health benefit plan on the date the service was requested and the treatment or service must cost the member at least \$100 if the member did not have insurance.

The member will be billed by the IRE for a \$25 filing fee. The fee will be refunded if the IRE finds in favor of the member. The fee can be waived if the IRE determines that it would create a financial hardship.

The request for an external review must be submitted to the address as listed on page 63. The request must include consent for the Third Party Administrator to release all necessary medical records to the IRE. The IRE must render a decision within twenty-one (21) calendar days of receipt of the information required from the Third Party Administrator. An extension is available to the IRE if both the member and the Third Party Administrator agree in advance.

Expedited External Appeal - An expedited external appeal is deemed necessary when a covered person is hospitalized or, in the opinion of the treating provider, review under the normal timeframe could, in the

MEDICAL CLAIMS APPEALS (CONTINUED)

absence of immediate treatment, result in any of the following:

- Placing the health of the covered person or, with respect to a pregnant woman, the health of the covered person or the unborn child in serious jeopardy;
- Serious impairment of bodily functions; or
- Serious dysfunction of a bodily organ or part.

An expedited external appeal may be requested orally with a follow-up letter.

The IRE shall render a decision within twenty-four hours from receipt of all information required from the Third Party Administrator. An extension of 24 hours is available to the IRE if both the member and the Third Party Administrator agree.

Coverage Denials

If the member is not satisfied with the decision of the internal appeal of a coverage denial, the member may request a review by the Kentucky Office of Insurance, Division of Health Insurance Policy and Managed Care, Attn: Coverage Denial Coordinator, P. O. Box 517, Frankfort, KY 40602. The request must be in writing, and should include copies of both the initial denial letter and the internal appeal decision letter.

The Kentucky Office of Insurance may either overturn or uphold the decision of the internal appeal or they may

allow an external review by an independent review entity (IRE) if a medical issue requires resolution.

Administrative Appeal for prescription drug changes

An Administrative Appeal allows any employee covered under the KEHP to appeal a change in the prescription drug formulary. Requests for an Administrative Appeal must be submitted to the Department for Employee Insurance, Administrative Appeal Committee, 501 High Street, Second Floor, Frankfort, KY 40601.

Pursuant to KRS 18A.2254, the employee shall have sixty (60) days from the date of the notice of the formulary change to file an appeal with the Personnel Cabinet. The Cabinet shall render a decision within thirty (30) days from the receipt of the request for an appeal.

Humana AND THE Commonwealth

a *great fit in 2008*

The Humana advantage

With any medical plan you choose for 2008, you get great benefits – plus these extra features and services from Humana:

- **Humana ChoiceCare Network PPO®.** With all of your health plan options, this provider network gives you a wide choice of participating hospitals and healthcare professionals.
- Answers to your questions. If you have questions about plan benefits during your enrollment period or anytime during the year, call Humana's Kentucky Employees Health Plan Customer Service and open enrollment hotline at **1-877-KYSPIRIT (1-877-597-7474).**

Here are examples of what you can do at MyHumana:

- View your **medical claims** for up to 18 months
- **Look up in-network doctors** and other healthcare providers
- Review a **Summary Plan Description** and order replacement **ID cards**
- Visit any of 17 **Condition & Health Centers** to explore all aspects of a condition, take assessments, use tools to track a chronic condition.

Humana Welcome

Kentucky Employees Health Plan Members
You're going to like what you see.

Humana and Express Scripts are the Commonwealth's partners for next year's healthcare benefits. That's great news for you and your family. You'll have a choice of four medical plans, as well as many additional features and services at no extra charge.

Important: Please supply information about other coverage. If your plan covers more than one person, you'll receive an automated call from Humana in January about coverage through another health plan. We need this information before we can process your claims. [Read more.](#)

Extra features at no cost to you
No matter what plan you choose, you get these extra features and services from Humana — at no extra charge:

- **Nationwide network of providers** with the Humana/ChoiceCare Network PPO®
- **Answers to your questions:** 1-877-KYSPIRIT (1-877-597-7474)
- **Access to MyHumana, where you can:**
 - Look up participating providers
 - Manage your Flexible Spending Account (FSA) or Health Reimbursement Account (HRA) funds
 - Review your plan benefits
 - View your medical claims
 - Find health and wellness information
 - Access the Health Risk Assessment toolTo access the Health Assessment tool, log in to MyHumana and click the Take Your Health Assessment link in the Health Resources section

Humana Guidance when you need it most

Members Plans & Products Enrollment Center Health & Wellness Tools & Resources

Home Members

Members
RightSourceSM, Humana's mail-order prescription service, is one of many ways we free up your time for more important things.

Log In to MyHumana
Username:
Password:
Log In >
[Forgot User ID/Password?](#)

Register Today >

Plans & Products
Our medical plans, pharmacy plans, and spending accounts are designed to fit every need.

Tools & Resources
Humana's calculators and other tools help you make informed healthcare decisions.

Enrollment Center
Get tips and use Humana's online tools to enroll in an employer group plan.

Health & Wellness
We provide information and assistance to support your efforts toward good health.

Highlights
Previous ●○○○○ Next

RightSource
Humana's mail-order prescription service
• Home delivery
• Savings opportunities
• 90-day supply
• Help from a pharmacist
[Find Out More >](#)

Provider Search
• Physician Specialist
• Hospital
• Pharmacy
• Dentist
• Urgent Care Center
• Other Facility/Service

Quick Links
• View ID Card
• Drug List
• Medicare Drug List
• Medicare Plans
• Mail-Order Rx
• Spending Accounts
• Humana Access Card

[About Humana](#) | [Company Information](#) | [Newsroom](#) | [Investor Relations](#) | [Careers](#)
[Humana.com Home](#) | [Members](#) | [Employers](#) | [Agents](#) | [Providers](#) | [Site Map](#) | [Humana.com Feedback](#)

- **Custom Website** developed exclusively for the Kentucky Employees Health Plan members. Simply log on to **kyhealthplan.humana.com** and register for MyHumana, your personal, password-protected home page, to find the resources you need.

- **Tools on MyHumana:** Humana provides easy-to-understand data to help you choose doctors and hospitals, and to make other informed decisions with confidence. The tools include simple numbers and graphics to: find out about hospitals, doctors, and outpatient centers; track what you've spent and how much a new procedure will cost; and manage your Flexible Spending Account (FSA) or Health Reimbursement Account (HRA). Many of these tools exist within MyHumana currently, and soon more will be available.



- **Wellness Solutions program** – You'll have access to a wide variety of health and wellness resources – including health coaching, preventive reminders, wellness newsletters, and a personalized health assessment. The assessment is a totally confidential lifestyle questionnaire about your health and wellness. The individualized results help you identify where your health is now and what you can do to improve it.
- **Informed care management** – These programs are designed to assist and educate members about managing their ongoing medical conditions. All services are completely confidential. Your personal health information is never shared with your employer.
- **HumanaFirst® Nurse Advice Line** – If you want to discuss your illness or injury with a nurse before going to urgent care or the emergency room, call the 24-hour, toll-free information line – at **1-800-622-9529**. The registered nurse will help you determine whether to manage your care at home or see a medical professional. This service is not intended for life-threatening emergencies. In case of emergency, call 911.

- **“Why Weight Kentucky”** – In this weight management program, a trained nurse care manager offers telephone support and education to help members reach their weight loss goals safely. Confidential phone conversations might include discussions about benefits of exercise and nutrition, community and Internet-based weight-loss resources, and identifying and overcoming barriers to weight loss. If you're taking a prescribed weight-loss drug, you'll need to enroll in the program to continue filling these prescriptions as a covered benefit.

We're here for you when you need us.

So be sure to take advantage of the year-round guidance and support Humana provides.

Humana's Kentucky Employees Health Plan Customer Service and open enrollment hotline:

1-877-KYSPIRIT (1-877-597-7474)
kyhealthplan.humana.com

HUMANA
Guidance when you need it most

Kentucky
 UNBRIDLED SPIRIT™

Humana Privacy Notice

financial *Information*

PRIVACY NOTICE CONCERNING FINANCIAL INFORMATION

Humana and our affiliates understand that the privacy of your personal information is important to you. We take your privacy seriously and your trust in our ability to protect your private information is very important to us. This notice describes our policy regarding the confidentiality and disclosure of personal financial information.

How Does Humana Collect Information About You?

We collect information about you and your family when you complete applications and forms. We also collect information from your dealings with us, our affiliates, or others. For example, we may receive information about you from participants in the health care system, such as your doctor or hospital, as well as from employers or plan administrators, credit bureaus, and the Medical Information Bureau.

What Information Does Humana Receive About You?

The information we receive may include such items as your name, address, telephone number, date of birth, Social Security number, premium payment history and your activity on our Web site. This also includes information regarding your medical benefit plan, your health care benefits, and health risk assessments.

Where Will Humana Disclose My Information?

We may share your information with affiliated companies and non-affiliated third parties, as permitted by law. We may also provide your information to other financial institutions with which we have joint marketing agreements in order to provide you with offers for products and services you may find of value or which are health-related.

What Can I Prevent With An Opt-Out Disclosure?

You can prevent the disclosures to non-affiliated third parties that provide products and services not offered by Humana or where the non-affiliated company provides services related to your plan by requesting to opt-out of such disclosures. Your opt-out request will apply to all members or individuals covered under your identification number or member account. Your opt-out request will continue to apply until you revoke your request or terminate your membership.

How Do I Request An Opt-Out?

At any time you may instruct Humana not to share any of your personal information with affiliated companies that provide offers of non-Humana products or services. If you wish to exercise your opt-out option, or to revoke a previous opt out request, you need to provide the following information to process your request: your name, date of birth and your member identification number. Any of the methods below can be used to request or revoke your opt-out:

- Telephone us at 1-866-861-2762,
- E-mail your opt-out request to us at privacyoffice@humana.com,
- Send your opt-out request to us in writing:
Humana Privacy Office
P. O. Box 1438
Louisville, KY 40202

Humana follows all federal and state laws, rules, and regulations addressing the protection of personal and health information. In situations when federal and state laws, rules, and regulations conflict, Humana follows the law, rule, or regulation which provides greater member protection.

The following affiliates and subsidiaries also adhere to Humana's privacy policies and procedures:

- Humana Employers Health Plan of Georgia, Inc.
- Humana Health Insurance Company of Florida, Inc.
- Humana Health Plan of Ohio, Inc.
- Humana Health Plan of Texas, Inc.
- Humana Health Plan, Inc.
- Humana Health Plans of Puerto Rico, Inc.
- Humana Insurance Company
- Humana Insurance Company of Kentucky
- Humana Insurance of Puerto Rico, Inc.
- Humana Medical Plan, Inc.
- Humana Wisconsin Health Organization Insurance Corporation
- HumanaDental Insurance Company
- The Dental Concern, Inc.
- The Dental Concern, Ltd.
- Humana Health Plan Interests, Inc.
- Humana Health Benefit Plan of Louisiana, Inc.
- Health One, Inc.
- Humana MarketPOINT, Inc.



Welcome to **EXPRESS SCRIPTS**

The Commonwealth of Kentucky has chosen us to manage your prescription drug plan.

We're here to help you save money and get the best service on prescriptions for you and your family. At a time when prescription costs are rising, Express Scripts provides affordable prescription drug plans to more than 50 million Americans.

Express Scripts features more than 1,000 Kentucky pharmacies in our national network, including Rite Aid, Kroger, Walgreen's, and Wal-Mart. We also include most of your neighborhood independent pharmacies.

Make the most of your pharmacy benefits. You can learn more about your pharmacy benefits by calling us at 877.KY.SPIRIT or visiting our website at www.express-scripts.com.



EXPRESS SCRIPTS®

ONLINE ENROLLMENT

Advantages of enrolling online

- Fast - you can finish enrollment in minutes!
- Easy - a series of questions will walk you through each step.
- Flexible - you can change your elections anytime during Open Enrollment.
- Private and Secure - your Employee ID and personal password allow you access to the enrollment site. The privacy of your personal information is our goal.
- Instant Confirmation - Once you receive your confirmation number, print out your enrollment information as soon as you complete the process - enter an email address and receive a confirmation message. **YOU SHOULD IMMEDIATELY REVIEW THE CONFIRMATION YOU RECEIVE. IF IT DOES NOT CONTAIN A CONFIRMATION NUMBER OR INDICATE THE BENEFITS YOU DESIRE, YOU MUST RE-ENROLL PRIOR TO THE END OF OPEN ENROLLMENT. PRINT OR WRITE DOWN YOUR ENROLLMENT CONFIRMATION NUMBER FOR YOUR RECORDS.**



If you are enrolling online, and wish to enroll in an HRA or a Flexible Spending Account (FSA), you must go through the entire enrollment process in order to complete the enrollment. You must complete the HRA and/or FSA sections prior to submitting your online enrollment. Failure to do so will result in no HRA or FSA benefit for 2008.

After enrolling for all benefits, you will receive a summary with your online enrollment elections. You must review the summary to ensure the benefits listed are what you elected. When elections are successfully completed, you will receive a confirmation. Print or write down the confirmation number for your records.

- Most participants will be able to enroll online, but there are a few exceptions. You will have to complete a paper Enrollment Application and submit it to your Insurance Coordinator if you are:
 - A KRS or KTRS retiree;
 - Paying by cross-reference with a KRS or KTRS retiree;
 - A new employee who has not yet enrolled for 2007; or
 - Switching the “primary” planholder on a cross-reference payment option.

Otherwise, your enrollment is in your hands - under your control!

CAUTION

When enrolling online, **do not exit the online application by closing the Internet** until you have completed the entire enrollment process.



You must click on “Accept”. You will receive a confirmation number. Print it or write it down and keep it for your records.

Do not hit the “Back” button during the enrollment process.

ONLINE ENROLLMENT

KRS & KTRS Retirees: Refer to instructions on page 100 specific to your enrollment choices.

The following is general information regarding the online enrollment process. You will find step-by-step directions at <https://openenroll.ky.gov>. You may also access the web enrollment system from <https://kehp.ky.gov>. A link to *Your KEHP Online Access* is provided.

A. Logging In

You will need your employee ID and your password.

Open Enrollment:

Existing employees: Before Open Enrollment, your employee ID and password will be mailed to your home through separate mailings. If you have not received your employee ID and/or password before the Open Enrollment period, contact your Insurance Coordinator or the Department for Employee Insurance. After obtaining your employee ID and password, log onto the Internet.

New employees: Obtain both your employee ID and password from your Insurance Coordinator and log onto the Internet. Depending on your benefit effective date, you may need to go through the enrollment process for each plan year affected (the current year and the upcoming plan year).

During The Plan Year:

New employees enrolling for the first time: Obtain both your employee ID and password from your Insurance Coordinator and log onto the Internet.

Note: You may use a home computer or a public computer when logging in.

To enlarge the page, click on the middle button located on the top right side of your screen. It should look like this:



ONLINE ENROLLMENT (CONTINUED)

Enter your employee ID and your password, then click on the "Login" button. These two (2) pieces of information allow you secure and private access to the program and also ensure no other person can log in and access your account.

| | |
|--------------------------------------|--------------------------|
| Employee ID: | <input type="text"/> |
| Password: | <input type="password"/> |
| <input type="button" value="Login"/> | |
| <input type="button" value="Exit"/> | |

Notes:

- Ensure your Num Lock is ON and your Caps Lock is OFF.
- Make sure the first 3 letters of the employee ID and the first 2 letters of the password are capitalized.
- After three (3) attempts, you will be locked out and will need to contact your Insurance Coordinator or the Department for Employee Insurance for a new password.

Review the instructions on the Welcome page, then click the "Continue" button at the bottom of the screen. If you are unable to see the "Continue" button, scroll down to the bottom of the screen using your arrow keys or the scroll bar on the right side of the screen.

B. Personal Information

On the "Employee Plan Elections" screen, click on the 'Select' link to view or edit a plan.

| | Year | Status | Date | Company | Plan Choice | Option | Level |
|------------------------|------|----------|----------|---------|-------------------------------|----------|--------|
| Select | 2007 | Active | 1/1/2007 | 55794 | 143 - KY Employee Health Plan | Enhanced | Family |
| Select | 2008 | Unedited | 1/1/2008 | 55794 | 143 - KY Employee Health Plan | Enhanced | Family |

If you are first directed to the demographics information, complete all fields and click the "Update Information" button.

ONLINE ENROLLMENT (CONTINUED)

If your demographics information has already been entered or you have just finished entering the information and clicked on the "Update Information" button referenced above, a summary of your information will be displayed for review. If a correction is necessary, click on "Change Information", update the information, and then click on "Update Information." If everything is correct, click the "Keep" button.

| Review Personal Information | |
|---|--|
| Please review the following information for accuracy | |
| Name: | DOE, JANE I |
| Address: | 45 ANYWHERE BLVD APT # 3 FRANKFORT, KY 40601 |
| Phone #: | 502-222-2222 |
| Gender: | FEMALE |
| Marital Status: | SINGLE |
| Date of Birth: | 12/12/1955 |
| E-Mail: | JANE.DOE@KY.GOV |
| <input type="button" value="Keep"/> <input type="button" value="Change Information"/> | |

Click on "Change Information" to update your personal information and "Keep" to continue with your enrollment.

C. Select a Health Insurance Plan or Waive your Insurance

If you choose to waive your coverage:

- The state contribution will be deposited into a Health Reimbursement Account (HRA).
- There are exceptions to the above, including but not limited to:
 - If you are already covered under a hazardous duty retiree.
 - If you are a retiree who has returned to work and you have chosen insurance coverage under the retirement system.

If you would like to elect health insurance coverage:

- Click the "Elect Coverage" button and fill in the requested information.
- If you wish to begin a new cross-reference payment option, you may continue with your enrollment session.
- If you are already a member in a cross-reference payment option and you are *not* switching planholders for the upcoming year, you may continue with your enrollment session.
- If you are already a member in a cross-reference payment option, and you wish to switch the planholder for the upcoming year, you and your spouse will need to complete a paper application and submit it to your Insurance Coordinator. Your web enrollment session is complete.
- If you are already a member in a cross-referenced payment option and you would like to end it, you and your spouse will need to complete separate paper applications and submit them to your Insurance Coordinators. Your coordinators

ONLINE ENROLLMENT (CONTINUED)

will need to mail these applications to DEI. Your web enrollment session is complete.

New employees:

- If you are a new employee and wish to begin a cross-reference payment option, your spouse will need to complete a paper application and there is nothing further for you to do. Your web enrollment session is complete.
- If you do not wish to begin a cross-reference payment option, proceed with your enrollment session.

Dependents:

- If you have elected a Couple, Parent Plus or Family level, you will need to add your new dependents and/or verify information for existing dependents. Refer to pages 79-81 for the definition of an eligible dependent.
- If you had existing dependents, review to ensure all information is correct. You may click on the "Change" button to update the dependents or click on the "Keep" button to keep all information shown.
- If you did not previously have dependents on your plan, click the "Add Dependent" button and complete the appropriate information for each dependent you wish to add.

Add Dependent

- After completing each dependent's information, click the "Save Changes" button.

Save Changes

- When all dependents have been added, click the "Finished" button

D. Commonwealth Choice FSAs

If you would like to enroll in a Health Care or Dependent Care FSA, click on "Commonwealth Choice FSAs".

- For information regarding FSAs, refer to pages 56-59 of this Handbook.
- There are four (4) choices: Planholder Healthcare FSA, Planholder Dependent Care FSA, Spouse Healthcare FSA, Spouse Dependent Care FSA.

ONLINE ENROLLMENT (CONTINUED)

- If you or your cross-referenced spouse would like to elect a Healthcare FSA, choose Planholder Healthcare FSA for your own FSA and Spouse Healthcare FSA for your spouse's FSA.
- Enter the amount you wish to contribute for the year. The minimum annual contribution amount is \$120 and the maximum is \$5000.
- If you or your cross-referenced spouse would like to elect a Dependent Care FSA, click on Planholder Dependent Care FSA for your own FSA and Spouse Dependent Care FSA for your spouse's FSA.
- Select the appropriate Tax Filing Status

| | |
|--------------------|--|
| TAX FILING STATUS: | <input type="radio"/> Married, filing separately (Annual Max - \$ 2,500.00) |
| | <input checked="" type="radio"/> Married, filing jointly (Annual max - \$ 5,000.00) |
| | <input type="radio"/> Single, head of household (Annual Max - \$ 5,000.00) |

- Enter the amount you wish to contribute for the year. The maximum annual contribution amount is \$5000.

E. Enrollment Complete

When you have completed your enrollment elections, you will need to review all of your choices and, most importantly, accept the choices as your final elections.

- Read the information.
- Carefully review your health insurance, HRA and FSA elections and read the disclaimer.
- Choose to either ACCEPT or DECLINE your elections.

If you do not click the "Accept" button at the bottom of the page, the elections and/or updates you have just entered will be LOST.

If you Decline your enrollment elections, you will need to go through the enrollment process again. None of the elections that you have just made will be activated. You must enter all elections and/or updates again and ACCEPT them before they can take affect.

If you ACCEPT your enrollment elections, you will receive a CONFIRMATION screen which contains your plan information and an enrollment CONFIRMATION NUMBER.

| |
|---|
| Confirmation |
| Update completed! Please keep the following information for your records: |
| Confirmation Number: 7D6810101939135FDA |

ONLINE ENROLLMENT (CONTINUED)

This confirmation is proof of your enrollment. PRINT IT or WRITE IT DOWN and keep it for your records. Do not throw it away.



F. Updates and Changes

You may update your health insurance and/or FSA elections anytime during the Open Enrollment period. Once Open Enrollment is over, no further updates will be allowed.

During the plan year, you may view your health insurance and FSA elections and update your personal information (address, phone number, etc).

- To update your personal information during the plan year, log on to *Your KEHP Online Access* at <https://kehp.ky.gov> using your employee ID and password. Refer to section A, Logging In, for instructions.

During Open Enrollment, you may update any previously made elections. However, you must ACCEPT your enrollment elections again at the end of each enrollment session. If you do not accept your elections each time an update is made, your updates will be lost.

Note to KRS and KTRS Retirees:

Retirees who are no longer actively employed -

You may not complete your retirement elections using the KEHP's Web Enrollment System. You must complete a paper Enrollment Application for your retirement health insurance benefits and submit it to your retirement agency.

Pre-65 retirees who have returned to work -

You must complete a paper Enrollment Application with your retirement agency and your active employer. Refer to the instructions below regarding your enrollment choices:

KRS Retirees - If you have returned to work, you may choose one of these three scenarios:

- a. An insurance plan with KRS, and a waiver with no HRA with your active company
- b. A waiver with no HRA with KRS, and an insurance plan with your active company.

ONLINE ENROLLMENT (CONTINUED)

c. A waiver with no HRA with KRS, and a waiver with HRA with your active company.

KTRS Retirees - If you have returned to work, you may choose one of these two scenarios:

- a. A waiver with no HRA with KTRS, and an insurance plan with your active company.
- b. A waiver with no HRA with KTRS, and a waiver with HRA with your active company.

65 and older retirees who have returned to work -

You must complete a paper Enrollment Application with your active employer. Note the following information regarding funding and eligibility:

- a. If you are receiving KRS or KTRS funds towards a Medicare Supplemental plan, you are NOT eligible to receive state funding through your active employer for either a stand-alone HRA or an insurance plan.
- b. If you are not receiving KRS or KTRS funds towards a Medicare Supplemental plan, you are eligible to enroll for coverage and receive state funding through your active employer.

NOTICE OF CREDITABLE COVERAGE

Prescription Drug Information for Kentucky Employees Health Plan Medicare Eligible Plan Participants

This notice confirms that your existing prescription drug coverage through the Kentucky Employees Health Plan is on average as good as or better than the standard Medicare prescription drug coverage (Medicare Part D). **You can keep your existing group prescription coverage and choose not to enroll in a Medicare Part D Plan.**

With this Notice of Creditable Coverage, you will not be penalized if you later decide to enroll in a Medicare prescription drug plan. **However, you must remember that if you drop your entire group coverage through the Kentucky Employees Health Plan and do not enroll in a Medicare Part D Plan after your existing group coverage ends, you may be penalized if you enroll in a Medicare Part D Plan later.**

If you keep your existing group coverage, it is **not** necessary to join a Medicare prescription drug plan this year.

REMEMBER: KEEP THIS NOTICE FOR FUTURE REFERENCE

ELIGIBILITY AND ENROLLMENT

Eligible Participants

1. Full-time employees

Regular full-time employees of the following agencies who contribute to one of the state-sponsored retirement systems, or who are otherwise defined in KRS 18A.225, are eligible to participate:

- State Agencies
- Boards of Education
- Health Departments
- Members of quasi governmental agencies who pay into a state-sponsored retirement system and have elected to participate in the Kentucky Employees Health Plan (KEHP)
- School Board members participate on a post-tax basis only. Board members are responsible for the payment of the total premiums per KRS 160.280(4)

2. Retirees

Retirees under age 65 (or age 65 or older and not eligible for Medicare) who draw a monthly retirement check from any of the following retirement systems are eligible to participate:

- Kentucky Judicial Retirement Plan
- Kentucky Legislators Retirement Plan
- Kentucky Retirement Systems (KRS)
- Kentucky Teachers' Retirement System (KTRS)
- Kentucky Community and Technical College System (KCTCS)

3. COBRA Qualified Beneficiaries

Eligible COBRA participants who were previously covered under the KEHP.

4. Dependents

The following dependents are eligible for participation under the Kentucky Employees Health Plan (KEHP):

- An employee's spouse under an existing legal marriage
- A member's unmarried dependent child

KEHP dependent child eligibility rules

Unmarried dependent child: For purposes of our health insurance Plan, an unmarried dependent child is a member's blood child, stepchild, adopted/placed child, foster child or grandchild, who meets the following eligibility rules:

- lives with the member for more than half of the calendar year;
- does not provide over one-half of his/her own support during the calendar year; and
- is less than 24 years of age at the end of the NEXT calendar year;

Adding a dependent to the Plan who does not meet the KEHP eligibility rules may be considered insurance fraud.

The Department for Employee Insurance reserves the right to request supporting documentation to verify the eligibility of any dependent enrolled or requesting to be enrolled in the Plan.

ELIGIBILITY AND ENROLLMENT (CONTINUED)

Temporary absences, such as for school, are permitted.

A dependent child who does not live with the member, but for whom the member or his/her spouse has a legal obligation under a divorce decree, court order or administrative order to provide for the health care expenses of the child, remains eligible for coverage under the Plan.

A foster child must have been placed by an authorized agency or by judgment, decree or court order.

A grandchild meets the above eligibility rules only when the member has guardianship or custody papers.

Age restrictions do not apply to a child that is permanently and totally disabled.

For purposes of our health insurance Plan, an unmarried disabled dependent may *continue* to be covered under the Plan beyond the age limit specified under the eligibility rules if the disability started before the limiting age and is medically certified by a physician.

A total disability is defined as the condition that results when any medically determinable physical or mental condition prevents a dependent from engaging in substantial gainful activity and can be expected to result in death or to be of a continuous or indefinite duration. The KEHP's Third Party Administrator may require proof

of the dependent's disability at least annually.

A disabled dependent not covered under the Plan prior to the limiting age may only be enrolled in the KEHP if he/she loses other health insurance coverage.

If, during Open Enrollment, you wish to enroll a disabled dependent that is past the limiting age specified under the eligibility rules, you must show proof that the disabled dependent has experienced a loss of coverage. The request to add the disabled dependent must be made within thirty (30) calendar days of the qualifying event (QE).

Working Families Tax Relief Act (WFTRA) of 2004

In the Working Families Tax Relief Act (WFTRA) of 2004 (I.R.C. § 152), Congress changed the way the Internal Revenue Service treats children under the tax code. This change may affect planholders if they pay their health insurance premiums pre-tax through the KEHP's Section 125 cafeteria plan.

The WFTRA of 2004 developed a new definition for "qualified child" and "qualified relative." An employee will NOT be able to pay dependent premiums on a pre-tax basis if the employee's dependent(s) **CANNOT MEET ONE** of these definitions (qualifying child or qualifying relative). In nearly all circumstances, if the dependent meets KEHP eligibility criteria, they will also meet one of these federal definitions. The KEHP

ELIGIBILITY AND ENROLLMENT (CONTINUED)

dependent eligibility rules shall always be met before a dependent can be enrolled in the KEHP.

Pursuant to I.R.C. § 152, the new definitions are as follows:

A “qualifying child” (QC) is a child who:

- has a specific, family-type relationship to the member-taxpayer.
- resides with the member in his/her household for more than half of the tax year (with certain exceptions such as “temporary absences” if a full-time student).
- is under age 19 and not a full-time student (or under age 24 if a full-time student) as of the end of the calendar year in which the member’s taxable year begins.

There is no age requirement if a child is permanently and totally disabled.

- has not provided more than half of his/her own support. The member-taxpayer no longer has to provide over half of the dependent-child’s support for the tax year, unless s/he is a full-time student.

A “qualifying relative” (QR) is a child or other individual who:

- has a specific, family-type relationship to the member-taxpayer, and is someone who resides with the employee in his/her household for the member’s taxable year.

A person cannot be a “qualifying relative” of the member if at any time

during the taxable year the relationship between the member and the person violates federal, state, or local law.

- receives over half of his/her own support from the member-taxpayer.
- is not anyone’s (including the member’s) “qualifying child.”

IMPORTANT: I.R.C. § 152 does not change KEHP’s eligibility rules. It does not create any new category of eligible dependents, or make people who were previously ineligible for coverage now eligible. It simply redefines the way the IRS treats dependent children age 24 and over for tax purposes only. A dependent shall meet KEHP’s eligibility rules before an employee may add the dependent to the Plan. Adding a dependent to the Plan who does not meet the KEHP eligibility rules may be considered insurance fraud.

Paying dependent premiums on a pre-tax basis for an individual who does not meet the definition of “qualifying child” or “qualifying relative” may be in violation of federal tax law.

Eligibility Limitations

Employees, retirees and COBRA participants may only be covered under one (1) state sponsored plan.

Dependents may only be covered under one (1) state sponsored plan. In the case of a child from divorced parents, the parent with custody shall have first option to cover the dependent child, unless both employees agree otherwise in writing.

ELIGIBILITY AND ENROLLMENT (CONTINUED)

Levels of Coverage

Single - Covers the employee/retiree only

Parent Plus - Covers the employee/retiree and one or more children, but does not cover the spouse

Couple - Covers an employee/retiree and his/her legal spouse

Family - Covers an employee/retiree, his/her legal spouse and one or more children

Waiving Coverage

You have the option to waive (decline) coverage if you do not want the health insurance offered through the KEHP.

If you are a *new* employee and wish to waive coverage, you must make your elections online or by completing Sections I, V, and VIII of the Enrollment Application and turn it in to your agency's Insurance Coordinator no later than thirty (30) calendar days after your employment date, or the date specified by your employer (see Effective Dates for more details).

FAMILY CROSS-REFERENCE PAYMENT OPTION

What is the family Cross-Reference Payment Option?

This is a payment option available to two (2) legally married participating members in the KEHP that have at least one dependent.

Am I eligible to elect the 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) with at least one dependent;
- 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 within the enrollment deadline and file with their agency's Insurance Coordinator. If during Open Enrollment you enroll online, you will be required to enter both members' passwords via the web.

If you do not meet all of the requirements listed above, 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.

** The Commonwealth Select Plan is only available for active employees. Therefore, the Commonwealth Select Plan may not be selected by active employees who cross-reference with an eligible retiree.

Loss of employment and the 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 full regular family contribution. Although the terminating employee is no longer eligible to receive an employer contribution, he/she has not experienced a loss of coverage, and will remain covered under your family plan.

Other considerations

If you are currently enrolled in the KEHP and your spouse is hired by a participating agency, the current employee will be the primary planholder for the cross-reference payment option. Employees of new groups coming into the KEHP during the Plan Year are not eligible to begin a cross-reference payment option.

EFFECTIVE DATES

New Employees

If you are a new employee, most employers participating in the KEHP will allow you thirty (30) calendar days from the date you are hired to:

- Enroll in a plan
- Enroll in a plan and enroll in a Healthcare Flexible Spending Account (Optional). To enroll in an FSA, state employees, school board employees and certain quasi governmental agency employees must enroll online or by completing Sections I, VI and VIII of the Enrollment Application. All others must contact their Insurance Coordinator for more details about enrolling in an FSA.
- Waive (decline) coverage by completing Sections I, V and VIII of the Enrollment Application, or enroll online, and direct the employer contribution into an HRA.

The Enrollment Application, for active employees, is included in this Handbook and is also available on the KEHP web site at <http://kehp.ky.gov>, or you may request an application from your agency's Insurance Coordinator. You may also enroll online quickly and in a secure environment by using *Your KEHP Online Access*.

Coverage of a new employee will begin on the first day of the second calendar month following the employee's hire date. For example, if you are hired anytime during the month of January, your coverage will be effective March 1.

If you are an employee of a quasi governmental agency, you may have different guidelines regarding your effective date of coverage. You may have a waiting period longer than the first day of the second calendar month. Contact your agency's Insurance Coordinator for details. If your agency has a waiting period longer than the first day of the second calendar month, your online enrollment or paper application must be signed no earlier than sixty (60) days prior to the effective date and no later than thirty (30) days prior to the effective date of coverage. Employees who fail to make their health insurance elections or waive their coverage within the deadline will not have coverage and will not be allowed to enroll until the next Open Enrollment period or unless an appropriate Qualifying Event occurs.

Open Enrollment

All elections made during Open Enrollment will be effective January 1, 2008.

TERMINATION DATES

Terminating employment

The KEHP is a pre-paid health insurance plan. **Therefore, your health insurance will terminate on the last day of the month following the month in which your employment terminates.** For example, if you terminate employment anytime in March, your health insurance coverage will terminate April 30.

Dependents dropped during Open Enrollment

Any changes made during Open Enrollment that would terminate your plan or drop any dependents from your plan will be effective December 31, 2007. Dependents dropped during Open Enrollment are not eligible for COBRA, unless the removal is in anticipation of a Qualifying Event (make sure your Insurance Coordinator knows that the change is related to a Qualifying Event instead of an Open Enrollment change). If you experience a Qualifying Event between Open Enrollment and December 31, 2007, you will need to specify in writing if you wish that your Open Enrollment elections continue on January 1, 2008. Otherwise, any new elections made due to your Qualifying Event will roll over on January 1, 2008.

Termination for non-payment of premiums

The Plan has the right to terminate your coverage if premiums are not paid in full each month.

QUALIFYING EVENTS - (for Health Insurance only)

The KEHP is provided through a Cafeteria Plan. This allows you to pay for your health insurance premiums with pre-tax monies, which is a savings for you. Cafeteria Plans are administered according to federal laws and regulations. Those regulations state that if your health insurance is offered through a Cafeteria Plan, you cannot change your Open Enrollment choices unless you experience an appropriate Qualifying Event. The Department for Employee Insurance cannot modify the regulations related to Qualifying Events. The effective date for changes to your plan must be consistent with the Qualifying Event date. The change cannot take place before the event occurs.

If you experience a Qualifying Event during the Plan Year, you are allowed to make certain changes to your health insurance coverage. Those changes must be consistent with the Qualifying Event you experience and must be made within a limited time period. Contact your agency Insurance Coordinator or the Department for Employee Insurance, Member Services Branch for questions relating to Qualifying Events. You may also find a complete listing of Qualifying Events in your Summary Plan Description at <http://kehp.ky.gov>. It is important that you print and read the Summary Plan Description relating to your individual coverage. The SPD has specific information relating to your health plan. Additional information is also included in the Administration Manual.

Effective Dates

To add dependents:

Some Qualifying Events (such as marriage, birth, adoption, loss of group coverage, etc.) allow you to add dependents to your current coverage. Coverage for dependents being added to a plan will be effective on the first day of the first month after the employee's signature on the application or Dependent Add Form and after the event has taken place including adding a grandchild by court decree or guardianship. Keep in mind that this is a pre-paid health insurance Plan. Therefore, if you experience a Qualifying Event that allows you to add dependents, you may be in arrears for payment of premiums. If this happens, you will be responsible for any premiums due.

Exceptions:

Birth - children added due to this Qualifying Event are effective on the date of birth if the application is completed within the specified timeframe. Kentucky law requires that any newborn care be covered for thirty-one (31) calendar days from the date of birth, regardless of enrollment. However, to cover the newborn beyond thirty-one (31) calendar days, an Add Form must be completed, signed, dated and submitted to your Insurance Coordinator within sixty (60) calendar days from the date of birth (when adding the newborn only).

QUALIFYING EVENTS (CONTINUED)

If you are adding the newborn plus other dependents, the time limit for enrollment is thirty (30) days.

Adoption/Placement for adoption - children added due to this Qualifying Event are effective on the date of adoption or placement for adoption if application is completed within the specified timeframe. If you are adding the newly adopted/placed child only, the time limit is sixty (60) days. If you are adding the newly adopted child plus dependents, the time limit is thirty (30) days.

To drop dependents:

Some Qualifying Events (such as divorce, dependent ineligibility, death, gaining other group coverage, Medicare eligibility, etc.) allow you to drop dependents from your current coverage.

Health coverage for dependents dropped from a plan ends on the last day of the month in which the employee signs the Dependent Drop Form and must be consistent with the event date. The effective date cannot take place before the event date.

Exceptions:

Loss of eligibility or dependent status such as divorce, a child's marriage, a child's establishment of a separate primary residence - dependents dropped due to these Qualifying Events are terminated effective on the last day of the month in which the event occurs regardless of signature date.

Deadlines

Employees have no later than thirty (30) calendar days after the event occurs to sign and date the appropriate form requesting a change.

Exceptions:

- **Adding a newborn only** - employee has sixty (60) calendar days*
- **Adding a newly adopted or placed child only** - employee has sixty (60) calendar days*

**If the employee is requesting to add additional dependents (other than the newborn or the newly adopted/placed child), he/she will have 30 days (not 60) after the event to make the request, sign and date the application or Dependent Add Form.*

Pre-signing

In certain cases, the Department for Employee Insurance will accept a pre-signed form. Pre-signing is the ability of an employee to sign a form prior to a Qualifying Event taking place. The Department for Employee Insurance will accept a pre-signed form only in the following cases:

- Loss of Other Health Coverage
- Entitlement to Medicare
- Spouse/Retiree has a Different Open Enrollment Period - See below for details
- Gaining other group coverage

QUALIFYING EVENTS (CONTINUED)

Special processing guidelines

- The effective dates for Qualifying Events are based on the date the event occurred.
- In certain cases, the Department for Employee Insurance will accept a Notification Date. The notification date is the date the employee is notified by another source that an event affecting his/her eligibility for a different coverage has occurred. The Department for Employee Insurance will accept a notification date (in lieu of the event date) only in the following cases:
 - Eligibility for governmental programs (Medicare, Medicaid, Loss of KCHIP)
 - CHAMPVA
 - TRICARE
- Spouse/Retiree Has Different Open Enrollment Period: The following processing rules apply to this Qualifying Event:
 - The Qualifying Event date is the last day of the spouse/retiree's Open Enrollment period.
 - The application or form can be signed prior to the event date.
 - The effective date of the selected coverage will correspond with the effective date of the spouse/retiree's Open Enrollment elections.

Supporting documentation

The Qualifying Events listed below require supporting documentation to be submitted with the appropriate Dependent Add Form or Dependent Drop Form. If you are having difficulty getting the required supporting documentation, **DO NOT** delay in completing the required form. You only have thirty (30) calendar days to sign and date the form. Complete, sign, date and submit the form within the deadline and submit the supporting documentation at a later date, if necessary. Not having the needed supporting documentation is not a reason for an extension of the thirty (30) calendar day deadline.

Divorce/Legal Separation/Annulment

- If dropping spouse from the plan: Filed decree, legal separation, or annulment papers signed by a judge and date-stamped "filed."
- If enrolling due to loss of other coverage: Proof that you were covered under your spouse's plan and are no longer eligible (HIPAA certificate or letter from employer on letterhead, identifying the date of insurance termination and the persons who were covered by the policy).

Note: The Department for Employee Insurance reserves the right to request a copy of the filed divorce decree as deemed necessary.

QUALIFYING EVENTS (CONTINUED)

Adoption or placement for adoption

- Placement papers from the Cabinet for Health and Family Services;
- Signed and date-stamped “filed” papers from the court;
- Letter from the adoption agency on letterhead;
- Legal document from a U.S. Court; or
- Official document translated into English and/or copy of the child’s visa - if foreign adoption.

Judgment, decree or administrative order relating to health coverage for your child

- A filed and dated court decree;
- Agency Administrative Order;
- National Medical Support Notice;
- Adding a grandchild requires guardianship or custody papers; or
- Adding a foster child requires placement papers from the Cabinet for Health and Family Services, or a filed and dated court decree.

Employee, spouse or dependent enrolled in employer’s health plan becomes entitled to Medicare or Medicaid

- Initial eligibility letter from the Medicare/Medicaid Office.

Note: The Department for Employee Insurance reserves the right to request a copy of the Medicare/Medicaid card as deemed necessary.

Gaining KCHIP is NOT a Qualifying Event to drop coverage.

Loss of other group health insurance coverage that entitles employee or family member to be enrolled in accordance with HIPAA (**choosing not to continue to make COBRA payments is not a Qualifying Event**)

- HIPAA certificate from prior carrier; or
- Letter from employer/previous employer on letterhead identifying the coverage termination date and the person(s) covered under the policy; or
- Letter from insurance agency identifying the type of coverage, the reason for termination and the person(s) covered under the policy; or
- Termination letter from government agency under which previous coverage was held.

Gaining other group health insurance coverage

- Letter from employer, on letterhead, identifying the coverage begin date and the person(s) covered by the policy; or
- Copy of new health insurance ID card(s) for each covered person, stating the coverage begin date.

QUALIFYING EVENTS (CONTINUED)

Different Open Enrollment

- Letter from employer, on letterhead, identifying Open Enrollment deadlines, effective dates, and persons who are being added to or dropped from the policy. The Event date is the last day of the other Open Enrollment.

Guidelines for adding children (other than biological or adopted, such as grandchildren, stepchildren, foster children)

- Can be added to your coverage by selecting the Qualifying Event of Legal Guardianship, Administrative Order or Court Order on the Dependent Add Form.
- The effective date of coverage is the first day of the first month after the employee's signature date on the Dependent Add Form and must be consistent with the event date. The effective date cannot take place before the event date.
- The deadline to add children under this Qualifying Event is no later than thirty (30) calendar days from the Qualifying Event. The Qualifying Event date is the date that the Legal Guardianship, Court Order or Administrative Order is filed by the court and dated by a judge.

- The supporting documentation required:
 - to add grandchildren is legal guardianship papers or custody papers;
 - to add foster children is a letter from the Cabinet for Health and Family Services or a filed and dated court decree;
 - to add stepchildren not residing in your household is a court order.

All children added to an employee's health insurance coverage must meet the dependent eligibility requirements as described on pages 79-81.

The above described Qualifying Events are not the only events that allow you to add your eligible dependent children to your health insurance coverage. Other events such as marriage and loss of other group coverage also allow you to add eligible dependents to your plan.

QUALIFYING EVENTS (CONTINUED)

Important Qualifying Event facts

- The appropriate form must be completed, signed and dated within the specified deadlines. Applications and forms signed after the appropriate deadlines will not be accepted.
- Supporting documentation must be submitted when required. The inability to obtain the required supporting documentation is not a reason for an extension.

A complete list of the permitted Qualifying Events and necessary forms are included on the KEHP web site at <http://kehp.ky.gov>. You may also contact your agency's Insurance Coordinator or the Department for Employee Insurance, Member Services Branch for additional information regarding Qualifying Events.

HOW DO I KNOW WHICH FORM TO USE?

You should use the Enrollment Application for the following events:

- Initial enrollment at hire date (New Employee).
- New Retiree.
- If you experience a Qualifying Event that allows an option change and you wish to make a change.
- Open Enrollment (however, employees are strongly encouraged to enroll online for faster and more accurate results).
- If you are employed by a group that joins the Plan for the first time (New Group).
- If you previously waived health insurance coverage and now have experienced a Qualifying Event that allows you to enroll - you must enter the Qualifying Event date and a description of the Qualifying Event.
- To begin a new cross-reference payment option.

You should use the Dependent Add Form or the Dependent Drop Form:

If you are currently enrolled and you experience a Qualifying Event that allows you to add or drop dependents to/from your plan with no other changes to your health insurance coverage.

ELIGIBILITY AND ENROLLMENT GRIEVANCES

Any employee who is dissatisfied with a decision regarding enrollment or disenrollment (Qualifying Events) in the Plan may file a grievance to the Plan Grievance Committee. The employee must file the grievance no later than thirty (30) calendar days from the event or notice of the decision being protested.

Grievances must be filed in writing to:

Personnel Cabinet
Department for Employee Insurance
Attention: Grievance Committee
501 High Street, Second Floor
Frankfort, KY 40601

A grievance must include ALL of the following items:

- Name, Social Security Number and Agency where you are employed;
- A description of the issue(s) disputed by you;
- A statement of the resolution requested by you;
- All other relevant information; and
- All supporting documentation.

Any grievance that does not include all necessary information will be returned to you without review.

A written response will be mailed to you and your agency's Insurance Coordinator stating the decision of the Committee.

The Committee will review a second request only if additional relevant facts are provided.

NOTE: This grievance committee only reviews grievances for enrollment and eligibility. Any appeals for claims must be submitted as outlined on pages 62-65.

COBRA

COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1986, or COBRA, provides that virtually all employers who sponsor group health plans must permit covered individuals, who lose coverage under that plan as a result of certain enumerated events, to elect to continue their coverage under the plan for a prescribed period of time on a self-pay basis. Individuals who are entitled to COBRA continuation coverage are known as Qualified Beneficiaries.

If you have questions regarding your COBRA rights, contact your agency's Insurance Coordinator or the Department for Employee Insurance, Member Services Branch.

Frequently Asked Questions about COBRA

Who is eligible for COBRA continuation coverage?

In general, Qualified Beneficiaries include employees, their spouses, and dependent children who are covered under the plan the day before the Qualifying Event occurs. An amendment to the COBRA regulation, permits children born to, or placed for adoption with an employee while on COBRA, to be considered a Qualified Beneficiary.

Who administers COBRA for the Kentucky Employees Health Plan?

Humana has partnered with Ceridian COBRA Continuation Services to administer COBRA for KEHP members. Your agency's Insurance Coordinator will enter a member's new hire and COBRA Qualifying Event information through Ceridian's WebQE. Once the Insurance Coordinator has entered the required information, Ceridian will be responsible for notification letters, enrollment, premium collection, etc.

How are Qualified Beneficiaries Notified of their rights?

COBRA regulations provide that a group health plan is required to provide written notice of COBRA rights to each covered employee and his or her spouse, if any, when coverage under the plan first commences. The regulations require that group health plans furnish written notice of COBRA rights no later than ninety (90) days after their coverage begins. This written notice may be referred to as either the Initial Notice or the General Notice.

The Initial Notice (General Notice) will be mailed to you by Ceridian immediately after your Insurance Coordinator enters your new hire information or COBRA Qualifying Event information on Ceridian's WebQE online enrollment system.

TERMS YOU NEED TO KNOW

Adverse Determination

When a health plan reviews an admission, availability of care, continued stay or other healthcare service and decides that it is not medically necessary, appropriate or effective. Therefore, payment for the requested service is denied, reduced or terminated.

Allowable Expense

Charges for services rendered or supplies furnished by a health plan that would qualify as covered expenses and for which the Plan pays in whole or in part, subject to any deductible, coinsurance or co-payment included in the Plan.

Balance Billing

If you use *out-of-network* benefits, you may be "balance billed" for any amount not paid by your Third Party Administrator. This means the provider (doctor, hospital, etc.) may bill you for the amount that your Third Party Administrator did not pay, in addition to the amount of your coinsurance. Your Third Party Administrator's payment is made based on a fee schedule that would normally be used in Kentucky.

Coinsurance

A percentage of the eligible expenses that you are responsible to pay to the doctor, hospital, pharmacy, or other provider. This percentage may vary based on the services provided.

Coordination of Benefits

Coordination of Benefits occurs when a member is covered by one or more health insurance plans. There are federal guidelines that are used to determine which plan pays first for each member.

Deductible

The initial amount of medical or hospital expenses you must pay before your Third Party Administrator starts paying benefits.

Eligible Expenses

A provider's fee which: (a) is the provider's usual charge for a given service under the covered person's plan; (b) 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 geographical area; and (c) does not exceed the fee schedule developed by the Third Party Administrator. The term "eligible expense" and "reasonable and customary charge" may be interchangeable.

Formulary

A list of FDA approved drugs selected on the basis of safety, clinical efficacy, and cost-effectiveness. An experienced committee of medical experts compiles the list for your Third Party Administrator.

TERMS YOU NEED TO KNOW (CONTINUED)

Generic Drug

A drug that is equivalent to a brand name drug produced when patent protection lapses on the brand name drug.

In-Network

Physicians, pharmacies, hospitals and other providers who have contracted with a particular Third Party Administrator to provide services for members covered under that particular health plan.

Maximum Out-of-Pocket

The maximum dollar amount you will have to pay for covered medical expenses during the plan year. It does not include the charges resulting from balance billing or certain PPO services.

Non-participating provider

Any physician, hospital, pharmacy, etc., that does not have a contract with the Third Party Administrator. Non-participating providers can bill you any amount above the allowable charges. Those excess charges are not applied to your out-of-pocket maximum.

Out-of-network

Physician, pharmacies, hospitals, and other providers who do not have contracts with a particular Third Party Administrator to provide services.

Participating Provider

A physician, hospital or pharmacy, etc., that signs a contract with a Third Party Administrator. The participating provider will accept the allowable

charge as its charge and will not balance bill the member.

Pharmacy Benefit Administrator (PBA)

Entities that administer managed pharmacy programs, defined as the application of programs, services and techniques designed to control costs associated with the delivery of pharmaceutical care by (1) streamlining and improving the prescribing and dispensing process, (2) educating the healthcare consumer, and (3) controlling the cost of prescriptions dispensed.

Qualifying Event

An event that may allow an employee/retiree to make a mid-year election change in their coverage or, in some cases, their FSA. The change must be on account of and consistent with the Qualifying Event.

Self-Insurance

The Commonwealth is assuming the financial risk of paying for the healthcare of the Plan. As such, the KEHP will have a Third Party Administrator to assume the administration of the claims and other business-related functions for health insurance. A Pharmacy Benefits Administrator (PBA) will assume the administration of the claims and other business related functions for the pharmacy benefits.

TERMS YOU NEED TO KNOW (CONTINUED)

Third Party Administrator

An individual or an organization that processes and pays claims and/or provides administrative services on behalf of a patient or client.

Usual, Customary and Reasonable

A provider's fee which: (a) is the provider's usual charge for a given service under the covered person's plan; (b) 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 geographical area; and (c) does not exceed the fee schedule developed by the Third Party Administrator.

Utilization Review

An evaluation of the necessity, appropriateness, and efficiency of the medical services, procedures, and facilities on a prospective, concurrent, or retrospective basis.

DEPARTMENT FOR EMPLOYEE INSURANCE HIPAA PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW YOUR PROTECTED HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

This Notice describes the obligations of the Department for Employee Insurance (DEI) and your legal rights regarding your Protected Health Information (PHI) under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Among other things, this Notice describes how your PHI may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law. The Kentucky Employees Health Plan (KEHP) is a self-funded governmental plan and, therefore, we are required to provide this Notice of Privacy Practice to you pursuant to HIPAA. DEI is the plan sponsor.

The HIPAA Privacy Rule protects only PHI. Generally, PHI is individually identifiable health information, including demographics information, collected from you or created or received by a health care provider, health care clearing house, or your employer on behalf of a group health plan that relates to: 1) your past, present, or future physical or mental health or condition; 2) the provisions or health care to you; or 3) past, present, or future payment for provisions of health care to you. DEI does not maintain information regarding your specific medical condition but does

maintain PHI related to demographic information and other information that is necessary for determining eligibility and enrollment in the KEHP. If you have any questions about this Notice or about our Privacy Practices, please visit <http://personnel.ky.gov/benefits/dei/hipaa.htm> or contact Department for Employee Insurance, Attn; HIPAA Privacy Officer, 501 High Street, 2nd Floor, Frankfort, Kentucky 40601. The effective date of this Notice is January 1, 2008.

DEI Responsibilities

We are required by law to: 1) maintain the privacy of your PHI; 2) provide you with certain rights with respect to your PHI; 3) provide you with a copy of this Notice of our legal duties and privacy practices with respect to your PHI; and 4) follow the terms of the Notice that is currently in effect. We reserve the right to change the terms of Notice and to make new provisions regarding your PHI that we maintain, or as required by law.

How DEI May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your PHI under certain circumstance without your permission. The following categories represent the different ways that we may use or disclose your protected health information: 1) For Treatment; 2) For Payment; 3) For Health Care Operations; 4) To Business Associates; 5) As Required by

DEPARTMENT FOR EMPLOYEE INSURANCE

HIPAA PRIVACY NOTICE (CONTINUED)

Law; 6) To Avert a Serious Threat to Health or Safety; 7) To Plan Sponsors.

Special Situations

In addition to the above, the following categories represent other possible ways we may use and disclose your PHI. 1) organ tissue donation, 2) military and veterans; 3) workers' compensation; 4) public health risk; 5) health oversight activities; 6) lawsuits and disputes; 7) law enforcement; 8) coroners, medical examiners and intelligence activities; 9) inmates; and 10) research.

Required Disclosures

DEI is required to disclose your PHI to you (as a participant) and for Government audits.

Other Disclosures

Other disclosures may be made to your personal representatives, spouses and other family members and with written authorization.

Participant Rights

A participant has the following rights with respect to their PHI: 1) right to inspect and copy; 2) right to amend; 3) right to an accounting of disclosures; 4) right to request restrictions; 5) right to request confidential communications; and 6) right to a paper copy of this Notice.

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with DEI or with the Office of Civil Rights of the United States Department of Health and Human Services. To file a complaint with DEI please visit <http://personnel.ky.gov/benefits/dei/hipaa.htm>. All complaints must be in writing. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Right or with DEI.

IMPORTANT INFORMATION FOR RETIREES

Please note:

The following information regarding retirees is provided in its entirety by the Kentucky Retirement Systems, the Kentucky Teachers' Retirement System and/or the Judicial and Legislators Retirement Plan. Any questions regarding the following information should be directed to your respective retirement system.

THE ENROLLMENT APPLICATION IN THIS HANDBOOK IS FOR ACTIVE EMPLOYEES ONLY. RETIREES WILL RECEIVE AN APPLICATION FROM THEIR RETIREMENT SYSTEM. DO NOT COMPLETE THE APPLICATION INCLUDED IN THIS HANDBOOK.

Attention retirees of the Kentucky Retirement Systems (KRS) and the Kentucky Teachers' Retirement System (KTRS):

The Commonwealth Select plan will only be available for active employees in 2008.

Retirees under age 65 (Or Age 65 Or older and not eligible for Medicare)

If you are a retiree under age 65, you may continue health insurance coverage at the group rate provided you receive monthly benefits from the Kentucky Community and Technical College System, Kentucky Judicial Retirement Plan, Kentucky Legislators Retirement Plan, Kentucky Retirement Systems or Kentucky Teachers' Retirement System.

Most of your questions can be answered in this Handbook and your retirement system materials. If you are unable to find answers to your questions, contact the retirement office for assistance before completing the enrollment application provided by the Retirement System. Contact information for each retirement system is listed below:

IMPORTANT INFORMATION FOR RETIREES (CONTINUED)

For KCTCS Retirement Benefits call (859) 256-3100.

For Judicial Retirement Plan or Legislators Retirement Plan benefits call (502) 564-5310.

For information on Kentucky Retirement Systems' insurance benefits, call (800) 928-4646, menu option 2 or (502) 696-8800, menu option 2. Calling early during Open Enrollment will assist KRS in serving you better.

For Kentucky Teachers' Retirement System benefits call (800) 618-1687 or (502) 848-8500.

Verify that your deductions are correct

If you are a retiree of the Kentucky Retirement Systems the following guidelines apply:

- new retiree from state government employment, school board employment or KY State Police employment will begin their retiree health insurance the first day of their second month of retirement and see their first health insurance deduction, if any, from their second month's retirement payment. This is because their KEHP insurance from their former employer is paid a month in advance so they are covered through the end of their first month of retirement. The insurance deduction, if any, from their second month's retirement payment is for coverage that begins the first day of the second month of retirement (in the month, for the month).
- A new retiree from an employer other than those listed in the preceding paragraph will begin their retiree health insurance the first day of their first month of retirement and see their first health insurance deduction, if any, from their first month's retirement payment. The insurance deduction, if any, from their first month's retirement payment is for coverage beginning the first day of the first month of retirement (in the month, for the month).

IMPORTANT INFORMATION FOR RETIREES (CONTINUED)

If you are a retiree of the Kentucky Teachers' Retirement System, you should verify your deductions on your first pay check the end of January.

Retirees who return to work - Kentucky Teachers' Retirement System

Many retirees who are re-employed become ineligible for insurance through KTRS. If you are re-employed, contact KTRS to determine your eligibility for health insurance through KTRS.

Retirees who return to work - Kentucky Retirement Systems, Judicial Retirement Plan and Legislators Retirement Plan

Retirees who return to work with an agency that participates in the Kentucky Employees Health Plan **may not elect coverage through the retirement system and participate in the Health Reimbursement Account offered to employees.** Retirees who wish to participate in the Kentucky Employees Health Plan must choose to either participate through the retirement system or the employer. Retirees must also waive coverage with either the retirement system or the employer, whichever is not selected, to provide their healthcare coverage at the time they return to work in a full-time status with an agency that participates in the Kentucky Employees Health Plan.

Retirees with Service in more than one Retirement System

You are eligible for one contribution toward the cost of insurance. If you have service in more than one retirement system, you should elect coverage through only one system and waive with the other.

Retiree rates and/or contribution amounts

Retirees should contact their respective retirement systems for contribution amounts. The total premium rates outlined in this Handbook

IMPORTANT INFORMATION FOR RETIREES (CONTINUED)

are the same for active employees and retirees. However, the contribution amounts may differ from the active employee contribution.

Any portion of the insurance premium not paid by your retirement system will be deducted from your monthly retirement benefit. If the amount to be deducted is greater than your monthly benefit, the retirement system will bill you for any additional premium owed.

Available Plans and Options for Retirees

The Kentucky Employees Health Plan is pleased to offer a national Third Party Administrator to its employees and retirees. Retirees are encouraged to contact Humana and Express Scripts regarding provider network information. Both can be reached by calling (877) KYSPIRIT or 877-597-7474.

Where to send your application

If you choose to participate in the Kentucky Employees Health Plan, **DO NOT** send your completed enrollment application to the Personnel Cabinet, Department for Employee Insurance or directly to the Third Party Administrator. Doing so will delay processing of your application. All applications must be returned to the address at the top of the application.

Judicial Retirement Plan and Kentucky Legislators Retirement Plan Benefits

The amount, if any, that JRP or LRP contributes toward your health insurance premium depends upon your years of Kentucky governmental service credit. The maximum monthly contribution, as approved by the Kentucky Judicial Form Retirement System Board of Trustees and the percentage of payment, can be found in the JRP/LRP "Non-Medicare Eligible Memorandum" accompanying this Handbook.

IMPORTANT INFORMATION FOR RETIREES (CONTINUED)

Information for RETIREES of the Kentucky Retirement Systems

Retiree Rates and/or Contribution Amounts

The amount, if any, that KRS contributes toward your health insurance premium depends upon several different factors such as when your participation began, the total and type (hazardous or non-hazardous) of service credit you have and, if you purchased service credit, the date that purchase was made. If you are uncertain about the amount KRS may pay toward the cost of your health insurance premium, you should contact the KRS office. Your specific account information can only be discussed over the telephone if you have established a Personal Identification Number (PIN) from the KRS office.

Hazardous Duty Retirees

A hazardous duty retiree's spouse who is employed with an agency that participates in the Kentucky Employees Health Plan may only elect coverage through his or her spouse's retirement system account or through his or her active employment. The spouse who wishes to participate in the KEHP must choose coverage under the retired spouse's account or elect coverage through employment and waive coverage on the other. This also applies to spouses of retired legislators and judges who participated in the Kentucky Retirement Systems.

A beneficiary of a deceased hazardous duty retiree who is employed with an agency that participates in the Kentucky Employees Health Plan may only elect coverage through the retirement system or through his or her active employment. The beneficiary who wishes to participate in the Kentucky Employees Health Plan must choose coverage under the deceased retiree's account or elect coverage through employment and waive coverage on the other. This also applies to beneficiaries of deceased retired legislators and judges who participated in the Kentucky Retirement Systems.

PHONE NUMBERS AND WEB SITES

Personnel Cabinet
Department for Employee Insurance
Member Services Branch
501 High Street, Second Floor
Frankfort, Kentucky 40601
(888) 581-8834
(502) 564-6534
<http://kehp.ky.gov>

Kentucky Retirement Systems
(800) 928-4646, menu option 2
(502) 696-8800, menu option 2
(502) 696-8822 (fax number)
www.kyret.com

Kentucky Teachers' Retirement System
(800) 618-1687
(502) 848-8500
www.ktrs.ky.gov

Judicial/Legislators Retirement Plans
(502) 564-5310

Humana Insurance Company and its Affiliates
(877) KYSPIRIT
(877) 597-7474
kyhealthplan.humana.com

Express Scripts, Inc.
(877) KYSPIRIT
(877) 597-7474
www.express-scripts.com

This Handbook was prepared by:

The Staff of the
Kentucky Personnel Cabinet
Department for Employee Insurance

This Handbook is available in an accessible format upon request and is available on
the Internet at:
<http://kehp.ky.gov>

The Commonwealth of Kentucky does not discriminate on the basis of race, color,
religion, national origin, sex, age, disability, ancestry or veteran status. Reasonable
accommodations are provided upon request.

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