Commonwealth of Kentucky
Personnel Cabinet
Department for Employee Insurance

2007 Plan Year
Health Insurance Handbook

http://kehp.ky.gov

GENERAL INFORMATION

The Personnel Cabinet's Department for Employee Insurance (DEI) is responsible for the administration of the Kentucky Employees Health Plan (KEHP). However, the DEI does not make medical determinations related to your claims. The DEI has contracted with Humana (for physician, hospital, lab, etc.) and Express Scripts (for pharmacy) to administer all claims. For contact information for Humana and Express Scripts refer to page 92. Contact information is listed below for the DEI:

Personnel Cabinet
Department for Employee Insurance
200 Fair Oaks Lane, Suite 501
Frankfort, KY 40601
(502) 564-6534
(888) 581-8834
http://kehp.ky.gov

Disclaimer

The material contained in this Handbook is for informational purposes *only* and is not a contract. It is intended to highlight the benefits of and the eligibility requirements for the medical plans. 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 DEI, or your Third Party Administrator (TPA), may take adverse action against you, including but 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 DEI immediately if a dependent is no longer eligible for coverage or if you have questions or reservations about the eligibility of a dependent.

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Who to Contact

	CONTACT
Eligibility questions **Enrollment questions** **Qualifying Event questions** **To obtain forms/handbooks** **Address changes** **General benefit questions**	**Department for Employee Insurance** **Member Services Branch** **888-581-8834** **502-564-6534**
To obtain provider directories **Medical claims questions** **Medical ID cards** **Disease Management Program** **Personal Health Analysis**	**Humana** **1-877-KYSPIRIT** **1-877-597-7474**
Prescription Drug Formularies **Participating pharmacies** **Prescription drug claims** **Step Therapy** **Prior Authorizations** **CuraScript**	**Express Scripts** **1-800-KYSPIRIT** **1-877-597-7474**

WHAT'S NEW OR CHANGING?

Effective January 1, 2007

- The KEHP is offering a new fourth plan, called Commonwealth Select. This plan is a High Deductible Health Plan (HDHP). To determine if this plan is right for you or your family, review the Benefits Grid on pages 22 – 26 and the Commonwealth Select section on page 29. **The Commonwealth Select Plan is available for active employees only.**

- The KEHP is offering a Health Reimbursement Account (HRA) for employees who waive their health insurance coverage (refer to page 52 for additional information on this HRA).

- If you elect to waive coverage the Commonwealth will contribute $175 each month into a Health Reimbursement Account. **However, you must enroll to receive the employer contribution.** The employer contribution is NOT automatic. Refer to page 52 for additional information on enrolling.

- **Eligible over-the-counter expenses will be covered under the Flexible Spending Account and the HRA.**

- If you wish to enroll in and contribute your own money to a Flexible Spending Account (FSA), you must enroll during the Open Enrollment period. Federal regulations require that employees who wish to enroll in an FSA must do so every year.

- Local school board employees are eligible for the Commonwealth Choice FSA. For information regarding the FSA, refer to page 55.

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IMPORTANT – you MUST enroll if:

- you wish to enroll in the Commonwealth Select Plan;
- you wish to enroll in an FSA;
- you want to waive coverage and direct money to an HRA;
- you want to change your current coverage; or
- you want to add or drop dependents.

Federal regulations require employees enrolling in an HRA or FSA to enroll every year. If you do not enroll, you will not have an HRA or an FSA for the 2007 Plan Year

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, Inc. The 2006 Summary Plan Descriptions (SPD) are available on the web. The 2007 SPDs will be available at a later date. Review all information you receive from the DEI, Humana or Express Scripts, Inc. Before you have medical services performed, make sure they have been pre-certified, if applicable. **Payment for non-covered services is your responsibility.**

Plan your decisions wisely

Review the Benefits Grids on pages 22 – 26 to determine which option best suits your needs and the needs of your family.

Determine the amounts that will be deducted from your paycheck. After you have made your selections during Open Enrollment, you will not be allowed to change them unless you experience a Qualifying Event (refer to the Qualifying Event section on page 76) that would allow a change, or you have a break in service (employment) of 30 days or greater.

Enroll no later than October 27, 2006

Open Enrollment is October 16, 2006 through October 27, 2006. The 2007 Plan Year is not a total re-enrollment. **However, you MUST enroll if:**

- **you wish to enroll in the Commonwealth Select Plan;**
- **you wish to enroll in an FSA;**
- **you want to waive coverage and direct money to an HRA;**
- **you want to change your current coverage; or**
- **you want to add or drop dependents.**

Federal regulations require employees enrolling in an HRA or FSA to enroll every year. Failure to do so will result in you not having the HRA or FSA for the 2007 Plan Year.

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

Verify that your deductions are correct

Enrolling online will provide you with an immediate summary of your elections. **It's your responsibility to print and review your Confirmation, which will include specific premium information. It is also your responsibility to review your first paycheck for your 2007 Plan Year deductions.** For state employees, this is the December 15th paycheck. If it is not accurate, contact your agency's Insurance Coordinator. If the amount deducted from your paycheck is not correct for the plan and coverage level you selected during Open Enrollment, your agency's Insurance Coordinator should contact the Department for Employee Insurance to make the necessary corrections. If the deductions are consistent with your elections, no changes will be allowed.

Notify your agency's health Insurance Coordinator of any eligibility changes

You must notify your agency's health Insurance Coordinator if you experience life changing events that may impact eligibility for you or your dependent(s) such as, but not limited to:

- Birth of a child;
- Adoption of a child 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;
- Dependent becomes covered by another group health plan.

Review your FSA Information

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

If you are a local health department employee or certain quasi group employee, you must contact your Insurance Coordinator for details.

Retirees are not eligible to participate in the FSA program or the HRA.

Summary of Member Responsibilities

_____ Read all material received from the DEI, Humana and Express Scripts.

_____ Enroll (Refer to page 2 to determine if you must enroll).

_____ Print your confirmation (if you enroll online).

_____ Review your confirmation to determine if your elections are accurate.

_____ Verify your deductions on your first pay check in December.

OPEN ENROLLMENT INFORMATION

Open Enrollment Dates

Open Enrollment is October 16 – October 27, 2006. The deadline to enroll online (or sign your application and submit it to your agency's health Insurance Coordinator, if applicable) is October 27, 2006.

All records received by Humana from the Department for Employee Insurance on or before **December 2, 2006** will receive identification cards by January 1, 2007, if applicable. Enrollment records will be processed in the order they are received.

Is It Required That I Enroll for 2007?

You MUST enroll if:

- **you wish to enroll in the Commonwealth Select Plan;**
- **you wish to enroll in an FSA;**
- **you want to waive coverage and direct money to an HRA;**
- **you want to change your current coverage; 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 or Commonwealth Premier).

Remember, you may enroll online, unless 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 2006; or
- Switching the "primary" planholder on a cross-reference payment option.

If you are one of the above, you will have to complete a paper application and submit it to your Insurance Coordinator.

Waiving Health Insurance Coverage

If you wish to waive coverage for 2007, you may waive your coverage online, or you may complete a paper application and indicate that you are electing to waive your health insurance coverage by completing Sections I, V, and VIII of the paper application. **Remember, if you wish to waive and direct the employer contribution to an HRA, you must enroll during Open Enrollment.** Refer to page 52 of this Handbook for information on directing the Employer Contribution into a Health Reimbursement Account.

Benefit Fairs

The time and location of 33 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, Inc. will be available at each of the following Benefit Fairs to answer any questions you may have.

9/28/06	**Franklin** 8:00 a.m. – 6:00 p.m.	Frankfort Convention Center 405 Mero Street Frankfort, KY 40601
10/2/06	**Leslie** 2:00 p.m. – 6:00 p.m.	Leslie County Board of Education 108 Maple Street Hyden, KY 41749
10/3/06	**Rowan** 2:00 p.m. – 6: p.m.	Rowan County Board of Education Central Office Board Room, 121 East 2nd Street Morehead, KY 40351
10/3/06	**Nelson** 2:00 p.m. – 6:00 p.m.	Nelson County High School Freshman Gym 1070 Bloomfield Road Bardstown, KY 40004
10/4/06	**Jefferson** 8:00 a.m. – 6:00 p.m.	Kentucky Fair & Exposition Center West Hall Meeting Rooms 1 & 2 Louisville, KY
10/4/06	**Harrison** 4:00 p.m. – 8:00 p.m.	Harrison County High School Auditorium 320 Webster Ave Cynthiana, KY 41031
10/5/06	**Boyle** 2:00 p.m. – 6:00 p.m.	Inter-County Energy Cooperative Community Room, 1009 Hustonville Road Danville, KY 40422
10/5/06	**Mason** 2:00 p.m. – 6:00 p.m.	Mason County Middle School 420 Chenault Drive Maysville, KY 41056
10/5/06	**Boyd** 2:00 p.m. – 6:00 p.m.	Boyd County Middle School Theater 1226 Summit Road Ashland, KY 41102
10/9/06	**Hardin** 2:00 p.m. – 6:00 p.m.	New Highland Elementary School 110 W. A. Jenkins Road Elizabethtown, KY 42701

10/9/06	**Carroll** 4:00 p.m. – 8:00 p.m.	Carroll County Middle School Cafeteria 408 5th Street Carrollton, KY 41008
10/9/06	**Wolfe** 2:00 p.m. – 6:00 p.m.	Campton Elementary School Cafeteria 166 HWY 2491 Campton, KY
10/10/06	**Barren** 2:00 p.m. – 6:00 p.m.	Kentucky Banking Center, Inc 1530 South Green Street Glasgow, KY 42141
10/10/06	**Knott** 2:00 p.m. – 6:00 p.m.	Knott County Board of Ed 11569 Hindman Bypass Hindman, KY 41822
10/10/06	**Kenton** 2:00 p.m. – 6:00 p.m.	Northern KY Area Development District 22 Spiral Drive Florence, KY
10/11/06	**Cumberland** 2:00 p.m. – 6:00 p.m.	Cumberland Co High School Cafeteria 912 North Main Street Burkesville, KY 42717
10/11/06	**Madison** 3:30 p.m. - 6:30 p.m.	Madison Central High School Cafeteria 705 N. Second Street Richmond, KY 40475
10/11/06	**Pike** 2:00 p.m. – 6:00 p.m.	Pike Central High School 100 Winners Circle Pikeville, KY
10/12/06	**Taylor** 2:00 p.m. – 6:00 p.m.	Taylor County High School Cafeteria 300 Ingram Avenue Campbellsville KY
10/12/06	**Johnson** 2:00 p.m. – 6:00 p.m.	Johnson Central High School Cafeteria 257 North Mayo Trail Paintsville, KY 41240
10/12/06	**Montgomery** 2:00 p.m. – 6:00 p.m.	Montgomery Co High School Cafeteria 724 Woodford Drive Mt. Sterling, KY 40353

10/16/06	**Grayson** 3:30 p.m. – 7:30 p.m.	Grayson Co Middle School Auditorium 726 John Hill Taylor Drive Leitchfield, KY 42755
10/16/06	**Daviess** 2:00 p.m. – 6:00 p.m.	Daviess County Public Schools Learning Center 700 Parrish Plaza Drive Owensboro, KY 42301
10/16/06	**Pulaski** 2:00 p.m. – 6:00 p.m.	The Center for Rural Development 2292 South Hwy. 27, Suite 300 Somerset, KY 42501
10/17/06	**Union** 2:00 p.m. – 6:00 p.m.	Union County High School Auditorium 4461 US Hwy 60 West Morganfield, KY 42437
10/17/06	**Whitley** 2:00 p.m. – 6:00 p.m.	Whitley County Board of Education Board Room, 300 Main Street Williamsburg, KY
10/17/06	**McCracken** 2:00 p.m. – 6:00 p.m.	Western KY Community & Tech College Crounse Hall Atrium, 4810 Alben Barkley Drive Paducah, KY
10/18/06	**Lyon** 2:00 p.m. – 6:00 p.m.	Lyon County Public Library 261 Commerce Street Eddyville, KY 42038
10/18/06	**Calloway** 2:00 p.m. – 6:00 p.m.	Calloway County Board of Education Board Meeting Room, 2110 College Farm Road Murray, KY 42071
10/18/06	**Fayette** 4:00 p.m. – 8:00 p.m.	Dunbar High School Cafeteria 1600 Man O War Lexington, KY
10/19/06	**Jackson** 2:00 p.m. – 6:00 p.m.	Jackson County Area Technology Center 100 Education Mountain Drive McKee, KY 40447
10/19/06	**Warren** 2:00 p.m. – 6:00 p.m.	Greenwood High School Library 5065 Scottsville Road Bowling Green, KY 42104
10/19/06	**Christian** 2:00 p.m. – 6:00 p.m.	Christian County Board of Education Board Room, 200 Glass Avenue Hopkinsville, KY

CONTRIBUTION INFORMATION

Premium Conversion

Upon enrollment, you are automatically set up to have your health insurance premiums paid 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 the web site at http://kehp.ky.gov or you may contact the DEI.

Employee Contributions

Monthly Employee Contribution* – Non-Smoker

	Single	Parent Plus	Couple	Family	Family** Cross-Reference
Commonwealth Essential	Not offered	$58.26	$274.90	$339.12	$0
Commonwealth Enhanced	$0	$120.76	$378.92	$454.72	$10.30
Commonwealth Premier	$19.28	$180.48	$422.30	$502.90	$35.04
Commonwealth Select	$0	$92.88	$285.54	$341.58	$7.74

Monthly Employee Contribution* – Smoker

	Single	Parent Plus	Couple	Family	Family** Cross-Reference
Commonwealth Essential	Not offered	$90.04	$306.68	$370.90	$15.88
Commonwealth Enhanced	$15.88	$152.54	$410.70	$486.50	$26.18
Commonwealth Premier	$35.16	$212.26	$454.08	$534.68	$50.92
Commonwealth Select	$12.50	$117.32	$309.48	$365.46	$19.66

* Contribution is per employee

** Refer to page 73 for additional information on this payment option.

Total Monthly Premiums

This chart is for reference only and does not reflect charges that will be deducted from your pay check.

	Single	Parent Plus	Couple	Family
Commonwealth Essential	Not Offered	$583.28	$895.50	$998.64
Commonwealth Enhanced	$457.70	$702.02	$1,074.84	$1,197.92
Commonwealth Premier	$473.72	$729.74	$1,110.88	$1,237.96
Commonwealth Select	$443.30	$664.94	$934.94	$1,066.60

Employer Contributions

Monthly Employer Contribution* – Non-Smoker

	Single	Parent Plus	Couple	Family
Commonwealth Essential	Not offered	$525.02	$620.60	$659.52
Commonwealth Enhanced	$457.70	$581.26	$695.92	$743.20
Commonwealth Premier	$454.44	$549.26	$688.58	$735.06
Commonwealth Select	$443.30	$572.06	$649.40	$725.02

Monthly Employer Contribution* – Smoker

	Single	Parent Plus	Couple	Family
Commonwealth Essential	Not offered	$493.24	$588.82	$627.74
Commonwealth Enhanced	$441.82	$549.48	$664.14	$711.42
Commonwealth Premier	$438.56	$517.48	$656.80	$703.28
Commonwealth Select	$430.80	$547.62	$625.46	$701.14

ONLINE ENROLLMENT

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 2007. You will receive a confirmation with your online enrollment. You must review the confirmation to ensure the benefits listed are what you enrolled in for 2007.

- Most participants will be able to enroll online, but there are a few exceptions. You will have to complete the paper 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 2006; or
  - Switching the "primary" planholder on a cross-reference payment option.

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

Advantages of enrolling online

- Fast - you can finish enrollment in minutes!
- Easy - a set of questions will walk you through each step.
- Flexible - you can change your elections anytime during Open Enrollment.
- Private and Secure - your personal password will allow you access to the enrollment site. The privacy of your personal information is our goal.
- Instant Confirmation – 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 INDICATE THE BENEFITS YOU DESIRE, YOU MUST RE-ENROLL PRIOR TO THE END OF OPEN ENROLLMENT. KEEP A COPY OF YOUR ENROLLMENT CONFIRMATION FOR YOUR RECORDS.**

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" and print the confirmation for your records.

You will receive a confirmation notice via email (if you provide an email address). You must review that notice to ensure that your enrollment was completed with the benefits you desire.

If your enrollment is not accurate, you must go back into the system and enroll in the correct benefits.

Do not hit the "Back" button during the enrollment process.

ENROLL EARLY!!!!!!!

Web Enrollment Directions

Note to KRS and KTRS Retirees:
You may not complete your retirement elections using the Web Enrollment System. You must complete a paper application for your retirement health insurance and submit it to your retirement agency.

If you have returned to work, please 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.
c. A waiver with no HRA with KRS, and a waiver with an 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 an HRA with your active company.

A. Logging In

1	Have your password ready. Your password will be mailed to your home, prior to the beginning of the enrollment period. If you have not received your password, contact your insurance coordinator or the Department for Employee Insurance. New Employees enrolling for the first time, will obtain your Web Enrollment password sheet from your insurance coordinator and log onto the internet. ***Note:*** You may use a home computer or a public computer when logging in.
2	Go to www.openenroll.ky.gov/. To enlarge the page so the welcome page fills your entire screen click on the middle button located on the top right hand side of your screen. It should look like this:  **You may also access the Web Enrollment System from http://KEHP.ky.gov. A link to "Your KEHP Online Access" is provided.**
3	Review the instructions on the welcome page, and then click the "Continue" button at the bottom of the screen. If you are unable to see the continue button, please scroll down to the bottom of the screen using your arrow keys or the scroll bar on the right hand side of the screen.

4	Enter your social security number, date of birth and your Web Enrollment password, and then click the "Login" button. These three (3) 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.  ***Notes:*** **• Please ensure your Num Lock is ON and your Caps Lock is OFF.** **• Do not put dashes in the social security number.** **• Use the date format shown.** **• Make sure the first 2 letters of the password are capitalized.** **• After three (3) tries, you will be locked out and will need to contact your Insurance Coordinator or the Department for Employee Insurance for a new password.**
5	You will be directed to either your demographics information or to the member's main menu, depending on whether you are enrolling during the year as a new employee or enrolling during open enrollment.

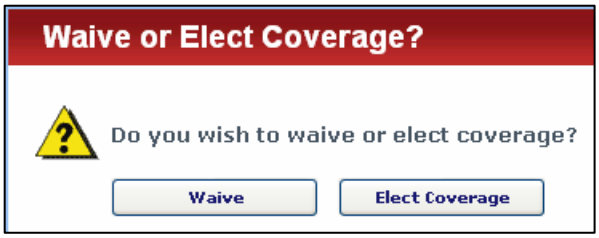
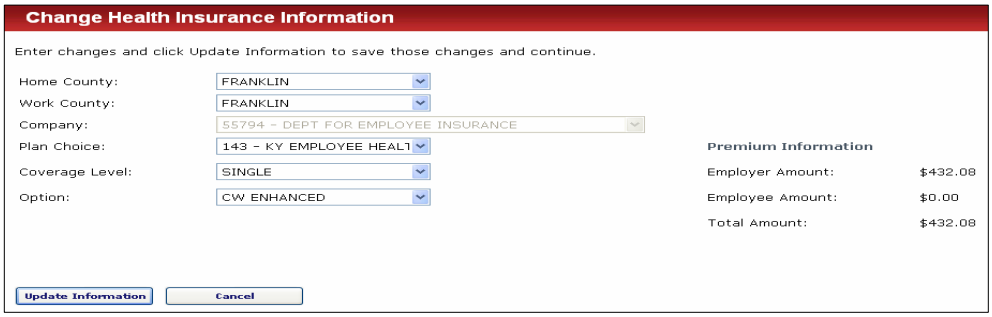
B. Personal Information

1	If you are first directed to the demographics information, please complete all fields and click the "Update Information" button. 
2	A quick review of your personal information is displayed next so you can make sure your corrections were saved. If everything looks correct, click the "Keep" button. If not, click on "Change Information" and you will be able to correct any errors. 
3	At "Member Main Menu", please go through the options in numerical order: First, enroll in Health Insurance or Waive your insurance benefit.

	Second, choose whether to enroll in a Flexible Spending Account (FSA). You may enroll in both types (Health Care and Dependent Care) if desired. Third, click on "Enrollment Complete". Do not click on this until you are absolutely sure you have explored all your enrollment options and are finished with your elections. 

C. Selecting a Health Insurance Plan or Waiving your Insurance

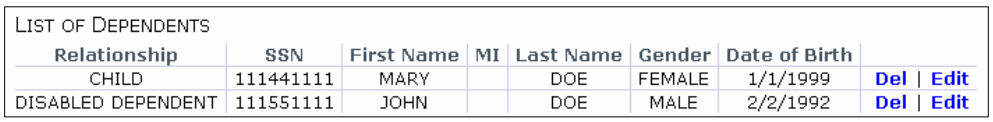
1	Click on "Health Insurance or Waive" on the main menu. This will bring you to the next step in the process. 1. Health Insurance or Waive
2	The Cross-Reference Payment Option Screen will be presented. Please read the information and choose accordingly. For details about cross-referencing, please refer to page 73 of this handbook. Open Enrollment: • If you are already a member in a cross-reference payment option, and you wish to switch the Plan Holder for the upcoming year, you and 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 are already a member in a cross-reference payment option and you are *not* switching Plan Holders for the upcoming year, you may continue with your enrollment session. • If you wish to begin a new cross-reference payment option, you may continue with your enrollment session. New Employees: • If you are a new employee and wish to cross-reference, click the "Yes" button. 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 cross-reference, click the "No" button and proceed with your enrollment session. 

3	Your employment hire date, health insurance coverage start date and signature dates will be presented for your review. After reviewing these, click the Continue button. 
4	Next, you will be asked if you wish to waive your insurance or elect insurance coverage.  If you choose to waive: • Click the "Waive" button and then answer the question regarding your smoking status. • If you are an active employee and you chose to waive, your state contribution will be deposited into a Health Reimbursement Account (HRA). There are exceptions, including but not limited to: o If you are already covered under a hazardous duty retiree, or o 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. The premium information will be displayed on the right side of the screen. • When you are satisfied with your elections, click the "Update Information" button. • If you are not satisfied with your elections press "Cancel" and you will be returned to "Member Main Menu". You may begin the enrollment process again. 

- 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 on the next screen.

  - ❖ If you had existing dependents, you will be directed to the "Review Dependent Information" screen. From there, you may click on the "Change" button to update the dependents or click on the "Keep" button to keep all information shown and move on the next section.

    - o If your dependents need to be updated and you clicked on the "Change" button, you will be directed to the "Change Dependent Information" screen. A list of your dependents will be presented on the top portion of the screen for your review.
    - o To delete a dependent, click on the "Del" link shown next to that dependent. (see below)
    - o To edit a dependent, click on the "Edit" link shown next to that dependent. (see below)



LIST OF DEPENDENTS

Relationship	SSN	First Name	MI	Last Name	Gender	Date of Birth	
CHILD	111441111	MARY		DOE	FEMALE	1/1/1999	Del | Edit
DISABLED DEPENDENT	111551111	JOHN		DOE	MALE	2/2/1992	Del | Edit

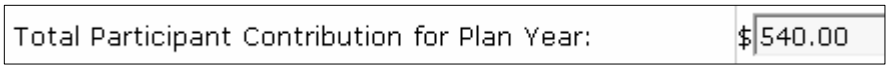
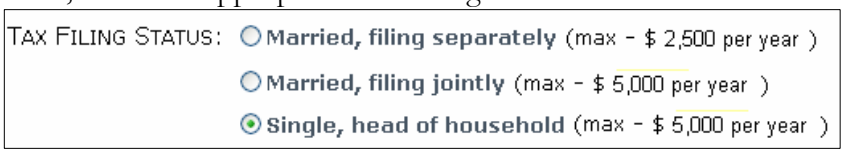
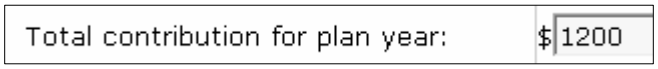
  - ❖ If you did not previously have dependents on your plan, you will be directed to the Change Dependent Information Screen.

    - o To add a dependent, click the "Add Dependent" button in the middle of the screen, then scroll down and complete the appropriate information for each dependent you wish to add.

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

    - o When all dependents have been added, click the "Finished" button at the bottom of the screen. The Member Main Menu will appear, ready for your next enrollment choices to be entered.

D. Commonwealth Choice FSAs

1	Click on "Commonwealth Choice FSAs" on the main menu. This will direct you to the "FSA - Participant Selection" Menu. **2. Commonwealth Choice FSAs**
2	On the "FSA-Participant Selection" Menu, there will be three (3) choices: Health Care FSA, Dependent Care FSA and Finished. For information regarding FSAs, please refer to page 55 of this handbook. 
3	If you would like to elect the Health Care FSA, click on **1. Health Care FSA** • Enter the amount you wish to contribute for the year.  • After entering your deduction amount, click "Update Changes" at the bottom of the screen.  You will be returned to the "FSA Participant Selection" Menu.
4	If you would like to elect the Dependent Care FSA, click on **2. Dependent Care FSA** • Next, select the appropriate Tax Filing Status  • Enter the amount you wish to contribute for the year.  • After entering your deduction amount, click "Update Changes" at the bottom of the screen.  You will be returned to the "FSA Participant Selection" Menu.

5	When you are finished enrolling, click on "Finished". You will be returned to the "Member Main Menu". 3. Finished

E. Enrollment Complete

1	Click "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. 3. Enrollment Complete
2	The "Authorization and Certification" screen will be displayed. **At this point your enrollment is not complete.** • Read the information at the top of the screen. • Carefully review your health insurance, HRA and FSA elections and read the disclaimer. • Scroll down to the BOTTOM OF THE SCREEN and choose to either **ACCEPT** or **DECLINE** your selections. Accept Decline **If you do not click the Accept button at the bottom of the page, the elections and/or updates you have just made will be LOST.**
3	**<u>If you Decline</u> your enrollment elections, you will be returned to the Member Main Menu 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.** **<u>If you ACCEPT</u> 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 **The Confirmation will be a full 8 ½ x 11 page with all of your enrollment information included.**

4	**This confirmation is proof of your enrollment. PRINT IT. Do not throw it away.** 

F. Updates and Changes

1	**You may update your Health Insurance and/or FSA elections anytime during your enrollment period. Once your enrollment period has expired, no further updates will be allowed.**
2	During the plan year, you may view your Health Insurance and FSA elections and update your personal information (address, phone number, etc). o To update your personal information during the plan year, please log on to "Your KEHP Online Access" at www.openenroll.ky.gov using your social security number, date of birth and your password. Refer to Section A, "Logging In", for instructions. o Your personal information will be presented for your review. If you need to change this, click on "Change Information" and make your changes. o When you are finished, click on "Update Information" on the bottom of the screen. During your enrollment period, you may update any previously made elections. However, you must click on "Enrollment Complete" from the "Member Main Menu" and RE-ACCEPT your enrollment elections at the end of each enrollment session. Refer to Section E, "Enrollment Complete" for instructions on how to ACCEPT your elections. If you do not re-accept your elections each time an update is made, your updates will be lost.

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 health insurance application is submitted within the applicable timeframes, pre-existing condition limitations do not apply to:

- 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 60 days of the date of birth, the date the child is legally adopted, or the date the child is legally placed for adoption.

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 plan benefits 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 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 health care expenses, the plan of the parent with that responsibility is primary.

Note:

Please indicate whether you or your dependents have other insurance by completing the information online or when you complete the paper 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.

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
Co-insurance	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 drugs 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 29 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 Deductible 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	20%* after emergency room co-pay	40%* after emergency room co-pay	10%* after emergency room co-pay	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
	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.							
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% co-insurance*	40% co-insurance*	10% co-insurance*	30% co-insurance*	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%*
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%*

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
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	
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.	

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**
Prescription Drugs									
Retail Pharmacy thirty (30) day supply									
	25%								
	Min	Max							
1st Tier	$10	$25		$5	40%	$5	30%	10%	30%
2nd Tier	$30	$50		$15**	40%	$15**	30%	10%	30%
3rd Tier	$35	$100		$30**	40%	$30**	30%	10%	30%
Mail Order (ninety (90) day supply									
	25%								
	Min	Max							
1st Tier	$20	$50		$10		$10		10%	
2nd Tier	$60	$100		$30		$30		10%	
3rd Tier	$70	$200		$60		$60		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 DEI 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 2007 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) from the TPA 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 20;
- Services, supplies and other care for acupuncture, anesthesia by hypnosis or anesthesia charges for services not covered by this 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 business, such as ramps, air conditioners, seat lift chairs or supplies or attachment for any of these items: penile implants; 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 treatment of a bodily injury or sickness;
- 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; and

- Services for the treatment of obesity, except as specifically indicated in the Summary Plan Description.

For additional exclusions, refer to the SPD. The 2006 SPD is on the KEHP web site at http://kehp.ky.gov. The 2007 SPD will be available at a later date. If you do not have access to the Internet, you may request a copy of the SPD by calling Humana at 877-597-7474.

Commonwealth Select

Refer to the Benefits Grid on Pages 22-26 for specific benefit information for the Commonwealth Select Plan.

The new Commonwealth Select Plan combines a PPO Consumer Driven Health Plan (CDHP) with a Health Reimbursement Account (HRA), **also referred to as a Personal Care Account (PCA).** An HRA is an "expense account" funded by your employer. The amount contributed to the HRA varies, depending on the level of coverage (single, family, etc.).

If you do not use all of the funds, you will be able to carry over the remainder of the unused funds to the next year as long as you continue to be enrolled in the Commonwealth Select Plan. If you use all of your HRA funds, you pay all additional medical expenses until you meet your annual deductible. If you discontinue enrollment in the Commonwealth Select Plan at any time, you forfeit any funds remaining in your HRA.

Benefits of the Commonwealth Select Plan

The Commonwealth Select Plan gives you choice and flexibility in how you pay for healthcare:

- Reduces your deductible with HRA funds. HRA funds can be used for expenses that apply toward your deductible, so you are "reducing" the deductible with funds supplied by your employer.
- Carry over unused dollars. If you have funds left over at the end of the plan year, you can keep them for next year as long as you continue enrollment in the Commonwealth Select Plan with the KEHP.
- Spend HRA dollars with the swipe of a card. Just use your Humana*Access*℠ Card to pay directly from your account.
- 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 under this Plan.

How Does the Commonwealth Select Plan Work?

Your employer will contribute money to your HRA if you elect the Commonwealth Select Plan for 2007. Your employer will provide the following funding:

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.

The entire amount will be available beginning January 1, 2007, or on the effective date of your coverage. Any unused funds will roll over into the 2008 Plan Year and will be available for your use in future years – as long as you continue enrollment in the Commonwealth Select Plan.

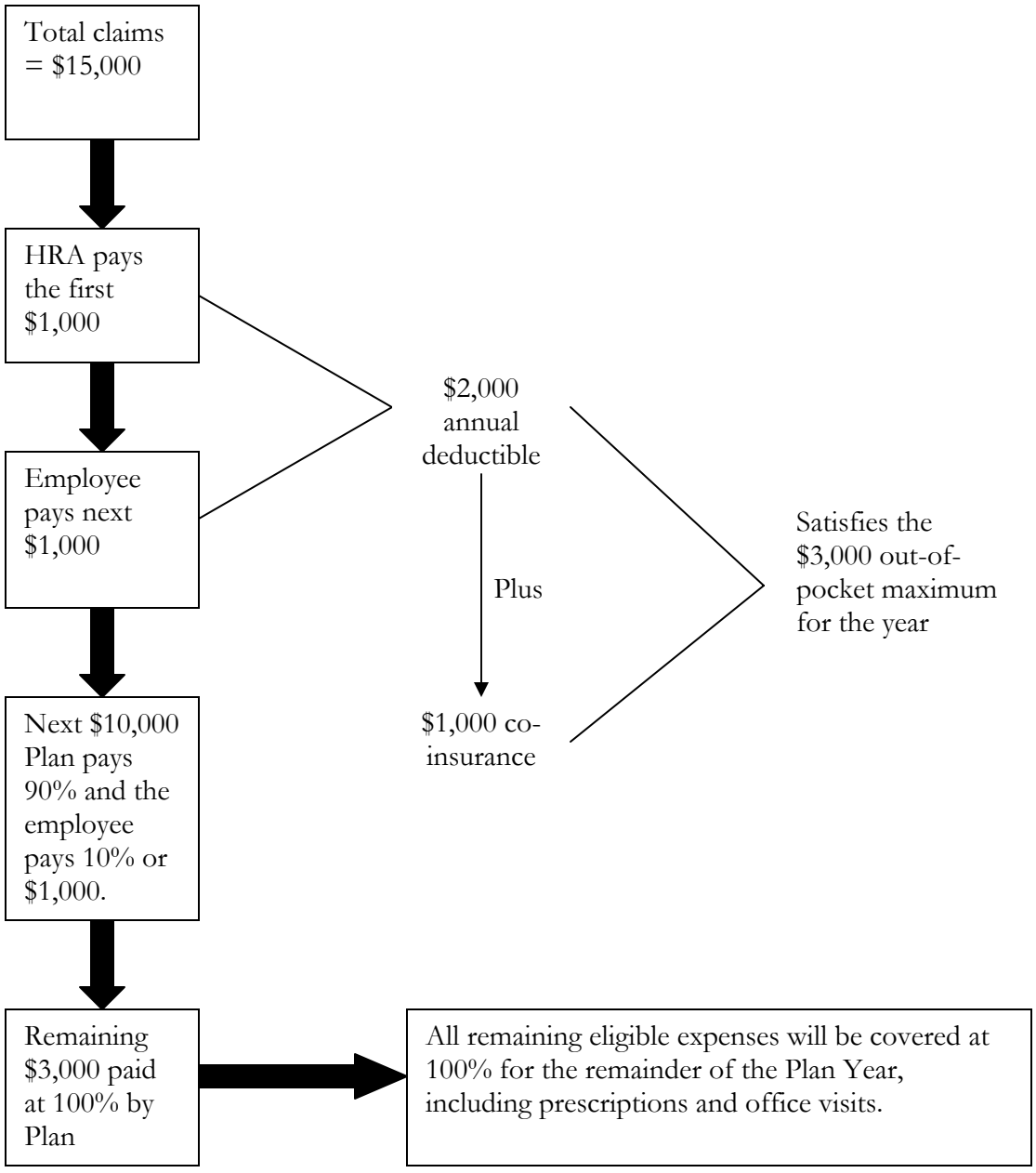
Note: In materials that you receive from Humana, an HRA may also be referred to as a Personal Care Account (PCA).

Let's look at some examples of how the Commonwealth Select Plan works.

Example 1

A single employee with the Commonwealth Select Plan whose total eligible annual health care costs are $15,000.

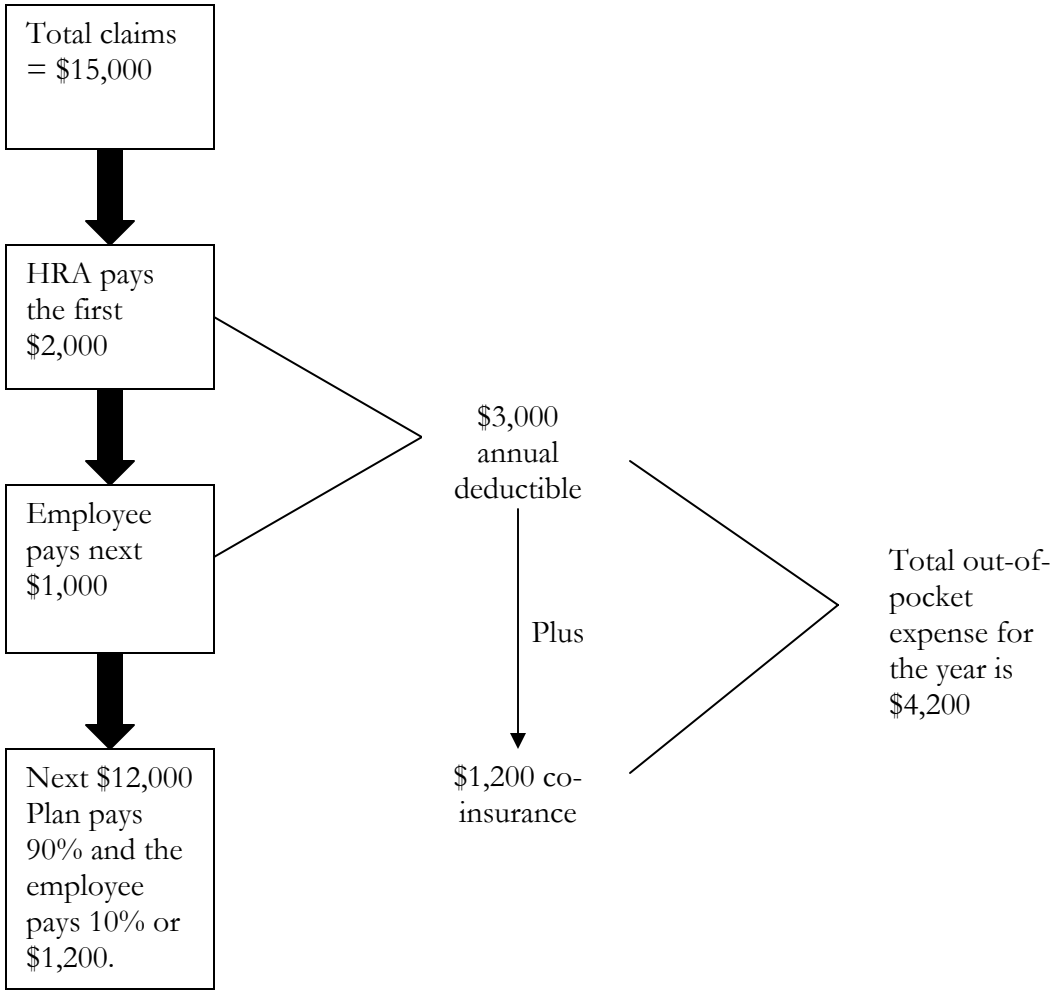
HRA funds = $1,000
Deductible = $2,000
Out-of-pocket maximum = $3,000



Example 2

An employee with a family Commonwealth Select Plan whose total eligible annual health care costs are $15,000.

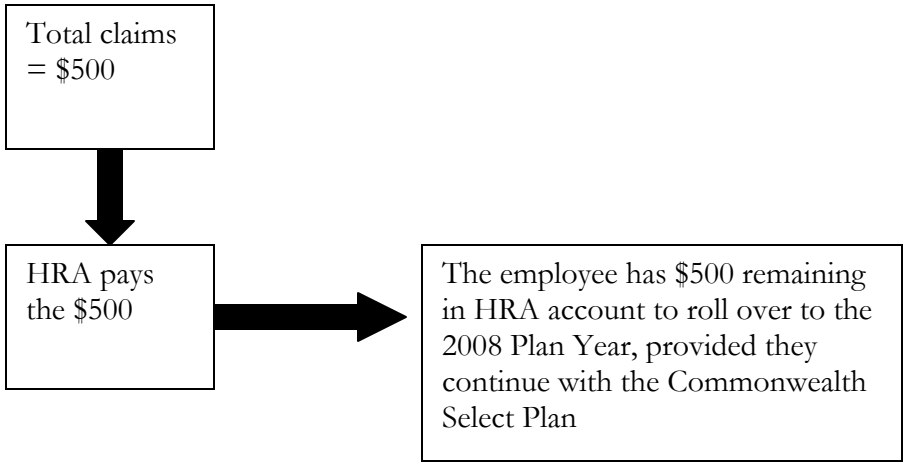
HRA funds = $2,000
Deductible = $3,000
Out-of-pocket maximum = $4,500



Example 3

A single employee with the Commonwealth Select Plan whose total eligible annual health care costs are $500.

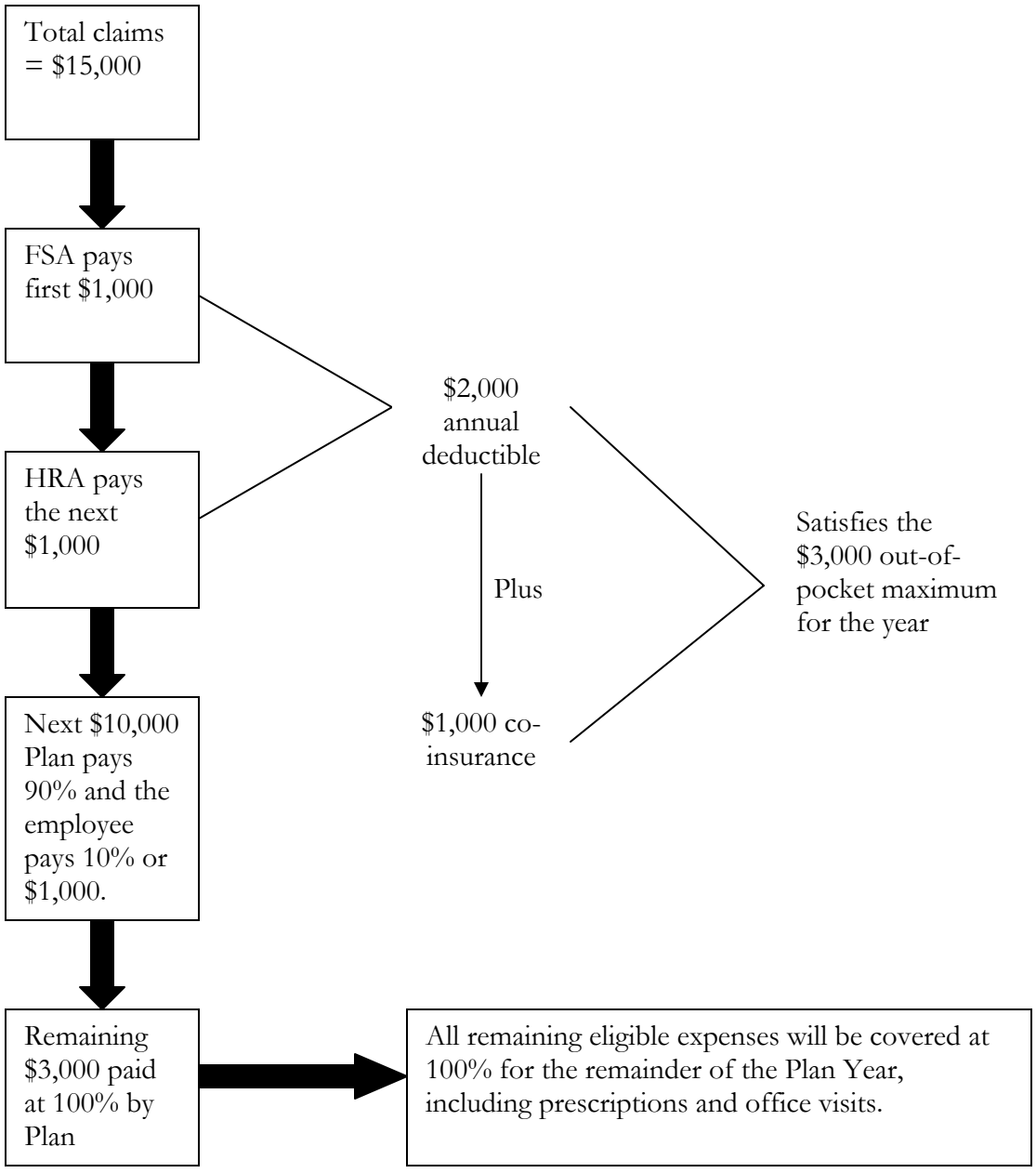
HRA funds = $1,000
Deductible = $2,000
Out-of-pocket maximum = $3,000



Example 4

A single employee with the Commonwealth Select Plan and a health care Flexible Spending Account totaling $1,000 whose total eligible annual health care costs are $15,000.

FSA Funds = $1,000
HRA funds = $1,000
Deductible = $2,000
Out-of-pocket maximum = $3,000



Using Your HRA Account

On the effective date of your coverage, you can start spending your HRA dollars on items approved by the KEHP from IRS eligible category lists.

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 co-insurance 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.

Using your Humana*Access* card

Once your Humana coverage begins, you'll receive a Humana*Access* Card in the mail. You can use this card at eligible healthcare locations where Visa debit cards are accepted. Save your receipts every time you use your Humana*Access* Card. Humana may ask for verification of charges, as required by the IRS.

Carrying over Unused Dollars

If you do not use all of your HRA funds, you can carry over any balance to the next year, as long as you continue with the Commonwealth Select Plan with the KEHP. Remember, if you terminate the Commonwealth Select Plan for any reason; you forfeit any unused funds in the HRA.

Consumer Driven Health Care

The Commonwealth Select Plan puts you, the member, in charge of your health care dollars. Using your health care wisely, will result in greater savings to you.

Frequently Asked Questions about the Commonwealth Select Plan

Are retirees eligible for the Commonwealth Select Plan?

The Commonwealth Select plan is being rolled out only for active employees in 2007. This will give the retirement systems time to analyze the plan for its potential benefit to retirees and to ensure statutory authority to offer this product, if it is deemed beneficial to their members.

Any questions regarding HRA eligibility can be addressed with the DEI or your retirement system.

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

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

If I choose the Commonwealth Select Plan for 2007, and have funds remaining at the end of the year, but choose another plan in 2008, 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 $1,000 to the HRA account?

The Commonwealth, or your employer, will fund the $1,000 contribution to 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 Humana*Access* 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 Humana*Access* card. If the provider refunds the difference to you and not to your Humana*Access* card, it is your responsibility to send that overpayment to Humana's HRA department to credit that amount 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 Humana*Access* card?

No. You must 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 Humana*Access* 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 health care Flexible Spending Account (FSA) to pay for other expenses and the co-insurance?

Yes. Your FSA money will always pay first.

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

Yes. Any funds paid out of your health care FSA account 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 co-insurance. For examples, 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 co-insurance would be based on the discounted cost.

Will my co-insurance 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 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 minimum medical costs will benefit from the Commonwealth Select Plan. Employees who have significant of 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.

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 an eligible expense 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. 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.

Prescription Drug Benefits

Express Scripts, Inc. (ESI) is the Pharmacy Benefit Manager (PBM) that administers the pharmacy benefit for the Kentucky Employees Health Plan. Express Scripts is not a subsidiary of Humana.

The KEHP utilizes the ESI nationwide pharmacy network, which includes most large pharmacy chains and many small independently owned pharmacies. In fact, most pharmacies in Kentucky participate with ESI's 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 US Food and Drug Administration (FDA) puts every generic drug through 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 US.

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-insurance.

The use of generic drugs saves the KEHP money, which can ultimately 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/co-insurance 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/co-insurance.

To qualify for the mail order benefit, the drug must be listed on ESI's maintenance drug list and you must have filled three thirty (30) day supplies 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 three thirty (30) day fills prior to receiving another supply at the reduced co-pay or co-insurance.

The mail order benefit is available either through Express Scripts mail order or at participating retail pharmacies. For a listing of the retail pharmacies participating in the mail

order program, please refer to the KEHP web site or contact ESI.

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 use and guard against overuse of such drugs.

CuraScript

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 who serves as your personal advocate and point of contact.
- Secure, express delivery of your specialty medications directly to you or your doctor.
- Supplies 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 1.866.413.4135 (8 a.m. – 9 p.m., Eastern time, Monday-Friday / 9 a.m. – 1 p.m., Eastern Time, Saturday). 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 noninjectable 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;
- Cost in excess of $500 for a 30-day supply.

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 criteria. If you take a new prescription to the pharmacy and the pharmacist says it requires prior authorization, ask your physician to call ESI's Prior Authorization line at 800-241-1390. Your physician must call for the prior authorization.

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 your new prescription when you change from a second-step drug to a first-step drug.

If your doctor decides, for medical reasons, that your treatment plan requires a second-step medication instead of a first-step medication, your doctor can contact ESI 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 3rd 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.

Frequently Asked Questions Regarding the Prescription Drug Benefit

Why is it necessary to have a formulary?

With the selection of drugs being so large and variable, a formulary is developed by Express Scripts based on which drugs they believe are safe, effective and economical. This allows the KEHP to continue to offer the 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. You may also request a copy by calling 1-877-597-7474.

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 program.

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 prescriptions drugs. Refer to page 62 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 already tried a first-step drug recently that's covered in the Step Therapy program, or
- your doctor decides you need a second-step drug for medical reasons.

If one of these applies to you, your doctor can contact ESI 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.

Prescription Drug Co-pay/Co-insurance In-network

Commonwealth Essential

Retail

Benefits will be paid at a 25% ***co-insurance*** 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% ***co-insurance*** 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% co-insurance

Refer to the Benefits Grid on pages 22-26 for out-of-network prescription drug benefits.

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

Disease Management Programs

INFORMED CARE MANAGEMENT: A PROGRAM FOR PEOPLE WITH CHRONIC CONDITIONS

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

ICM is a unique disease management 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 30 different conditions.

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

- Review your health information with you;
- 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 1 (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.

30 ICM CONDITIONS ADDRESSED INCLUDE:

- Asthma – adult & pediatric
- Breast Cancer
- Cerebrovascular Disease/Stroke
- Chronic Hepatitis
- Chronic Kidney Disease
- Colorectal Cancer
- Congestive Heart Failure
- Chronic Obstructive Pulmonary Disease (COPD)
- Coronary Artery Disease
- Cystic Fibrosis
- Diabetes – adult & pediatric
- End Stage Renal Disease
- Gastroesophageal Reflux Disease (GERD)
- Geriatrics
- HIV
- Hypercoagulable State
- Hypertension
- Inflammatory Bowel Disease – Crohn's Disease & Ulcerative Colitis
- Low Back Pain
- Lung Cancer
- Lymphoma/Leukemia
- Migraines
- Osteoporosis
- Parkinsonism
- Peptic Ulcer Disease
- Peripheral Artery Disease
- Prostate Cancer
- Rheumatoid Arthritis
- Seizure Disorders
- Sickle Cell Disease – adult & pediatric and even more are under development

Weight Management Program

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 new, free program that may help 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 Weight Management 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 medicines, or wish to take them, you must enroll in the Weight Management Program in order to continue filling these prescriptions as a covered benefit.

KEHP WELLNESS PROGRAMS

Smoking Cessation Programs

The KEHP has partnered with Express Scripts, Inc. 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 (1-800-QUITNOW). Additional information on these programs is included on page 45.

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 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 Programs?

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 1-800-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

Kentucky Tobacco Quit Line 1-800-QUIT NOW

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 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 1-800-QUIT NOW (800-784-8669) for help in finding a class.

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 1-800-QUIT NOW (800-784-8669). This is a proactive telephone counseling program in which you work with a personal quit coach to quit smoking. Call DEI's 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 DEI for a copy of the brochure. The voucher is available on the Personnel Cabinet's web site or by calling the DEI's Member Services Branch.

KEHP Wellness Programs

Maternity Program

As part of your health plan, you are invited to participate in ActiveHealth's Maternity Program. The Maternity 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.

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.

Personal Health Analysis (PHA)

The Kentucky Employees Health Plan, in partnership with Humana and Gordian Health Solutions, provides

every covered member with the opportunity to complete a PHA that allows them to evaluate their current health status. The PHA acts as a comprehensive report card for member's health habits and lifestyle. For example, there will be questions about physical activity, family history, seat belt usage and stress level.

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 a Disease Management Program. Humana will provide the Commonwealth with cumulative summary data from the completed PHAs with no identifying personal information. The PHA also offers you a one-time assessment from a health coach that can help you understand your report. 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 achieve wellness: mind, body and spirit!

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 www.humana.com.
- If you have not registered, 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 "Enter the Site".
- Click "Take Health Assessment"
- Once you have completed the PHA, you can go back to the PHA start page and print your report

Remember

Participation in the PHA or any Disease Management Program is strictly confidential. Neither your employer, nor the Commonwealth, will ever see your individual results

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 your need to change your health habits and work toward a healthier lifestyle.

Do Not Staple!

KENTUCKY EMPLOYEES HEALTH PLAN
PY 2007

HEALTH INSURANCE and SPENDING ACCOUNT
APPLICATION FOR ACTIVE EMPLOYEES

INSURANCE COORDINATOR SECTION

__/__/0__ Coverage Effective Date _____ Company Number

__/__/__ 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)

Gender
☐ < Male
☐ < Female

Marital Status
☐ < Married
☐ < Single

_____
Mailing Address

_____ City, State, Zip Code _____ County of Residence _____ Country / Mail Code, if not USA

_____ 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)
☐ < Commonwealth Essential
☐ < Commonwealth Enhanced
☐ < Commonwealth Premier
☐ < Commonwealth Select

2. Level of Coverage
☐ < Single
☐ < Parent Plus
☐ < Couple
☐ < Family

3. Cross-Reference Payment Option
(Available for Family Coverage Only)
☐ < 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)***	Is your spouse a Hazardous Duty Retiree?	Your spouse's Hire Date or Retirement Date:	Your spouse's Deduction Start Date (If BOE employee):
_____	☐ <Yes ☐ <No	☐ <Yes ☐ <No	_____	_____

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

Do you wish to waive your health insurance coverage and have the employer contribution of $175 per month deposited into a Health Reimbursement Account (HRA)? ☐ < Yes

KENTUCKY EMPLOYEES HEALTH PLAN

HEALTH INSURANCE and SPENDING ACCOUNT 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) 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 Pended 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 Health Insurance 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 Health Insurance 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 health insurance application.

Relationship Code: Enter the appropriate relationship code as follows:

SP Spouse (your eligible spouse).
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).
DD Disabled, Dependent Child (your eligible disabled child). If your disabled dependent child is 24 years old or older, your health insurance carrier 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 Plan Year 2007 and direct the employer contribution of $175 per month into an HRA.

If you do not mark Yes in this section, you will not receive the employer contribution of $175 per month for Plan Year 2007.

PY **2007**

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 FSA enrollment process.

Health Care → All amounts must be divisible by two.

The **minimum** allowable monthly contribution is $10 The **maximum** allowable yearly contribution is $2,880

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

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 = $2,500)

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

HumanaAccess℠

Upon enrolling in an HRA or an FSA, you will receive the HumanaAccess Visa debit card at no cost to you and with no transaction fee.

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 all benefits for my eligible dependents and me will be provided in accordance with the plan contract.
* 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

HEALTH INSURANCE and SPENDING ACCOUNT 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 ACCOUNT (FSA)

- This section can only be completed by employees of state agencies and boards of education.
- If you are an employee of a health department or quasi-governmental agency, you cannot use this section to enroll in an FSA. You must contact your IC regarding your 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 employees and boards of education) by the deadline.
- All amounts entered in this section are yearly amounts.

Health Care
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 Flexible Spending Account information, only if your spouse meets ALL of the following:

- He/she is a state employee or a board of education employee;
- 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.

Humana*Access*: 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 and boards of education employees), you will receive the Humana*Access* card at no cost to you and with no transaction fee. 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. ENROLLING ONLINE IS EASY, FAST AND SECURE. IF YOU ENROLL ONLINE, YOU WILL RECEIVE INSTANT CONFIRMATION THAT YOU HAVE ENROLLED!

Waiving Coverage and Health Reimbursement Accounts

Waiving Health Insurance

Employees who waive their health insurance may enroll in a Health Reimbursement Account (HRA) beginning January 1, 2007. Employees who waive must complete the waiver section of the application or online enrollment in order to have their employer contribution directed to an HRA.

Employer Contribution

The employer contribution for 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 to have the Commonwealth contribution directed to the HRA. If you enroll online, you must complete the entire enrollment process (see page 11 for additional information regarding online enrollment). If you complete a paper 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?

Health Reimbursement Accounts are federally qualified expense accounts that consist of funds set aside by employers to reimburse employees for qualified medical expenses. An HRA is not an insurance plan.

A health reimbursement account provides "first-dollar" medical coverage until funds are exhausted. For example, if an employer contributes $1,000 into an HRA, the employee will have first dollar coverage for any qualifying medical expense, up to the first $1,000. Under a health reimbursement account, the employer provides the funds, not the employee. All unused funds are rolled over at the end of the year, provided you remain with the same plan and continue with the KEHP. For example, if you waive coverage in 2007 and have $500 remaining in the HRA, as of December 31, 2007, that $500 will roll to the 2008 Plan Year provided you continue to waive coverage. However, if you enroll in a different plan, any funds remaining will be forfeited. The same occurs if you enroll in the Commonwealth Select Plan in 2007 and elect a different plan in 2008, you will forfeit any remaining funds in the HRA.

Frequently Asked Questions about an HRA

If I waive coverage and have the Humana*Access* card, will I be able to use that card to pay for my prescription drugs?

Participants who waive medical coverage will receive a Humana*Access* Card to pay for all out-of-pocket approved expenses at doctor's offices and hospitals. For pharmacy claims, Humana has contracted with pharmacies that participate in a special pharmacy network that will accept payment when Humana is not the medical provider.

What is the difference between an HRA and an FSA?

The main difference in an HRA and 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.

Can I contribute my own money into an HRA?

No, you cannot contribute money to the HRA. However, you can contribute pre-tax money to a health care 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. Due to IRS guidelines that govern cafeteria plans, 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 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 may enroll in an HRA online or by completing Sections I, V and VIII of the application.

When does coverage begin?

If you enroll during Open Enrollment: Coverage begins January 1, 2007.

For new employees: coverage begins on the first day of the second month following the date of hire. If you do not complete a form 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 Humana*Access* card in the mail. You can use this card for health care HRA—eligible expenses at healthcare locations where Visa debit cards are accepted, such as participating pharmacies, doctor's offices, and hospitals. When you use the card at a pharmacy, eligible charges are automatically deducted from your HRA fund. You can even present your Humana*Access* 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 typically

eliminates the need to submit claim forms and wait for reimbursement.

When will I receive my Humana*Access* 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 Humana*Access* 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 1-888-894-2201 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 Humana*Access* card to receive reimbursement for medical expenses?

No. You may submit your itemized bills to Humana for reimbursement if you prefer not to utilize the debit card.

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

Yes*. Humana has implemented a new process to allow you to pay at the pharmacy.

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

- 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 Humana*Access* card for payment or swipe it through the credit card machine.
- Select "credit" – not "debit" – for your transaction.
- Sign and save the receipt.

This service will be available starting January 1st, 2007, at pharmacies participating in the "Spending Account Secondary Payer Pharmacy Network." To find a complete list of participating pharmacies, please visit* ***kyhealthplan.humana.com.*

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 DEI. There are two types of FSA accounts available – a health care FSA and a dependent care FSA. The FSA accounts are offered through the Section 125 cafeteria plan and contributions are made on a pre-tax basis, which saves you money.

Let's look at an example of how the FSA can save you money.

	No FSA	With FSA
Annual Salary	$35,000	$35,000
Pre-tax FSA withholding to cover out-of-pocket medical expenses		- $1,000
Taxable Salary	$35,000	$34,000
Approximate Tax at 26%	- $9,100	- $8,840
Take Home Pay	$25,900	$25,160
Out-of-pocket medical expense after taxes	- $1,000	
Money left in your pocket after medical expenses	$24,900	$25,160
Saved by participating in the FSA		**$260**

What is an FSA?

A health care 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 health care FSA. You may enroll in one or both Flexible Spending Accounts offered by the Commonwealth. You may contribute specified amounts from your salary toward a Health Care Flexible Spending Account and/or a Dependent Care Account. You can use Health Care FSA dollars to pay toward out-of-pocket prescription costs; eligible medical expenses such as doctor's office visits, x-rays, and lab tests; and some services not covered by your health insurance plan. You can use Dependent Care FSA dollars to pay toward childcare services such as daycare or adult care.

Health Care FSA Eligible Expenses
(partial listing)

- Acupuncture
- Ambulance service
- Birth control pills and devices
- Chiropractic care
- Contact lenses (corrective)
- Dental fees
- Diagnostic tests/health screening
- Doctor fees
- Drug addiction/alcoholism treatment
- Drugs
- Eligible over-the-counter expenses

Experimental medical treatment
Eyeglasses
Guide dogs
Hearing aids and exams
Injections and vaccinations
In vitro fertilization
Nursing services
Optometrist fees
Orthodontic treatment
Prescription drugs to alleviate nicotine withdrawal symptoms
Smoking cessation programs/treatments
Surgery
Transportation for medical care
Weight-loss programs/meetings
Wheelchairs
X-rays

Dependent Care FSA Eligible Expenses
(partial listing)

After school care
Baby-sitting fees
Day care services
In-home care
Au pair services
Nursery
Preschool
Summer day camps

FSA Qualifying Events

The IRS requires that your enrollment in an FSA plan continues the entire Plan Year (January 1 through December 31); however, you may be able to change your current election and make a new election mid-year if you experience an eligible qualifying event. Some qualifying events that allow you to make a change in your health insurance may allow you to make a change in your Health Care FSA. Contact your health Insurance Coordinator or the Department for Employee Insurance for specific requirements and limitations on qualifying events for the FSA program.

Dependent Care FSA

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

- Log onto *My*Humana, 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 return with your receipts to:

Humana Spending Account Administration
P.O. Box 19068
Green Bay, WI 54307

- If you do not have Internet access, you may call Humana customer service at 1-800-604-6228, the Department for Employee Insurance, or your Insurance Coordinator to request a paper reimbursement form to fill out and send back.

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

Frequently Asked Questions about an FSA

Will my employer contribute to a Flexible Spending Account?

No. The FSA is entirely funded with employee money.

What are the Minimum and Maximum contribution amounts?

The minimum contribution is $10 per month for either the Health Care Flexible Spending Account or the Dependent Care Account.

The maximum contribution for the healthcare FSA is $2,880 per year. The maximum yearly contribution for Dependent Care Account depends on your tax filing status as listed below:

If you are married and filing separately, your maximum annual deposit is $2,500.
If you are single and head of household, your maximum annual deposit is $5,000.
If you are married and filing jointly, your maximum annual deposit is $5,000.
If either you or your spouse earns less than $5,000 a year, your maximum annual deposit 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 deposit is $3,000 for one dependent and $5,000 for two or more dependents.

Who is eligible to enroll?

All active state employees, local school board employees and certain quasi agency employees who are eligible for state-sponsored health insurance coverage are eligible to enroll in the Commonwealth Choice FSA. Employees of health departments and quasi groups may be eligible through their employer. Check with your Insurance Coordinator for details.

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

Yes. Eligible over-the-counter expenses can be reimbursed through the Health Care FSA. Refer to page 59 for a partial listing of eligible over-the counter expenses.

What timeframe do I have to submit my expenses for a health care FSA?

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

What timeframe do I have for submitting 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 FSA) and must be filed for reimbursement prior to March 31 of the following calendar year.

Is enrollment automatic?

No. If you are a state employee, board of education employee or certain quasi agency employee and you decide you want to participate in the FSA, you must enroll in the FSA program by web enrollment, or by completing Section I, VI and VIII of the paper application during Open Enrollment. During the Plan Year, you may enroll online or by completing Section I, VI and VIII of the application.

If you are an employee of any other agency, FSA programs may be available. Contact your agency's health Insurance Coordinator for more information about the enrollment process.

When does coverage begin?

If you enroll during Open Enrollment: Your coverage begins January 1, 2007.

New Employees: 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 a health insurance 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.

How do you access your health care FSA funds?

It's easy and convenient to access your **health care** FSA funds. Once your coverage begins, you will receive the free Humana*Access* card in the mail. You can use this card for health care FSA - eligible expenses wherever Visa debit cards are accepted, such as participating pharmacies, doctor's offices, and hospitals. When you use the card at a pharmacy, eligible charges are automatically deducted from your FSA fund. You can even present your Humana*Access* 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 typically eliminates the need to submit claim forms and wait for reimbursement.

When will I receive my Humana*Access* 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 you need to activate the Humana*Access* Card?

Yes. You will need to 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 1-888-894-2201 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.)

Your Humana*Access* Card is a free service available to you. There is no additional cost or transaction fee for using the card.

Eligible Over-the-Counter Expenses Reimbursed through Health Care FSA and HRA

Beginning January 1, 2007, the KEHP will allow eligible over-the-counter expenses to be reimbursed through the Health Care FSA and the HRAs.

Over-the-counter drugs will not be reimbursable with the Humana Access Card. You will have to purchase the over-the-counter drugs, obtain your receipt and submit a paper claim to Humana for processing.

Examples of over-the-counter drugs include, but are not limited to:

- Allergy medications
- Blood pressure meter
- Prilosec®

Examples of items that are not acceptable include, but are not limited to:

- Aromatherapy
- Baby wipes
- Facial care
- Hair regrowth

There are certain over-the-counter expenses that will require a letter from your doctor. Those include, but are not limited to:

- Foot spa
- Leg or arm braces
- Massagers
- Special supplements
- Special teeth cleaning system
- Vitamins

HUMANA*ACCESS* CARD

"Using your Humana*Access*℠ Visa® Debit card"

Activate it
If you waive medical insurance and enroll in a Health Reimbursement Account or HRA – sometimes called a Personal Care Account or PCA – you will receive a Humana*Access* card to pay for eligible expenses at healthcare-related locations wherever Visa is accepted. When you receive your card, call 1-888-894-2201 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 Humana*Access* 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 card to pay for other eligible healthcare expenses, such as:

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

Manage your balance
For your card payment to go through, you must have enough funds in your account. To see your current balance and account activity, log in to *My*Humana at **kyhealthplan.humana.com** and look under MyBenefits for the Personal Care Account or PCA heading and click on My Account. You can also check your balance by calling 1-800-604-6228.

Frequently Asked Questions Regarding the Humana*Access* card.

Do I need to save my statements from the providers when I use my Humana*Access* card?

Yes. IRS regulations require that Humana substantiate all reimbursements made with the Humana*Access* card. If they are not able to substantiate the expense through their claims system, you will be requested to submit the required paperwork to substantiate those reimbursements.

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

Humana may contact you through a letter requesting a receipt or Explanations of Benefits to verify that you used your card only for a qualified expense.
If you can not provide supporting documents, the IRS requires you to repay the expense. Write a check or money order to "Humana Insurance Company" for the full amount along with a completed reimbursement form. You can download a reimbursement form from *My*Humana at **kyhealthplan.humana.com**. Sign and date the form, and mail it to: Humana Spending Account Administration, P.O. Box 19068, Green Bay, WI 54307 or fax to 920-632-9200.

If you do not have Internet access, call Humana's Spending Account Customer Service Team at **1-800-604-6228** to get a

reimbursement form to complete and mail back.

How do I request reimbursement for an overpayment I made to my doctor using my Humana*Access* card?

If you overpay your doctor with your Humana*Access* 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:

1. Deposit the check into your personal bank account
2. Write a check on your account made out to Humana
3. Mail the check to the Green Bay address listed above

Be sure to note on the check which account the money goes into – FSA or HRA.

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

For your convenience, Humana will send two Humana*Access* cards in mail. You only need to activate one card for both to work.

Each card will give you access to both of your funds; HRA and FSA.

Medical Claims Appeals and Grievances

Appeals/Grievances

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

1. **Adverse Determination** – procedures performed or proposed to a covered person are not deemed medically necessary, by the insurer, or are experimental or investigational services and would result in coverage being denied, reduced or terminated. An adverse determination does not mean a determination that the health care services are limited or excluded by the plan, unless medical necessity is a result of the limitations or exclusions.

2. **Coverage Denial** – services, treatments, drugs or devices that are specifically limited or excluded under the covered person's plan.

3. **Administrative Appeals/Grievances** – 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 1st or 2nd tier co-pay).

Who Should Perform the Appeal?

Adverse Determination – Both the TPA and PBM will handle the Internal Appeal Process for Adverse Determinations in accordance with KRS 304.17A.600-633.

Coverage Denial – Both the TPA and PBM will handle the Internal Appeal Process for Coverage Denials in accordance with KRS 304.17A.600-633.

Administrative Appeals/Grievance – 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:

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 either the TPA or PBM's Customer Service Department first (the numbers are 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 TPA, 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 TPA or PBM's Customer Service Department, the employee may request an internal appeal. A request for an internal appeal must be submitted in writing within 60 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 TPA or PBM 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 covered person or the unborn child in serious jeopardy;
- Serious impairment of bodily functions; or
- Serious dysfunction of a bodily organ or part.

The TPA or PBM 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 TPA or PBM 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 TPA or PBM must have failed to make a timely determination or notification. In addition, the member must have been eligible on the date of service, or enrolled 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 TPA or PBM 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 TPA or PBM. An extension is available to the IRE if both the member and the TPA or PBM 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 absence of immediate treatment may 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 TPA or PBM. An extension of 24 hours is available to the IRE if both the member and the TPA or PBM 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.

How to File an Administrative Appeal/Grievance

Requests for an Administrative Appeal must be submitted to the Department for Employee Insurance, Administrative Appeal Committee, 200 Fair Oaks Lane, Suite 501, Frankfort, KY 40601.

The Committee will review the request for an Administrative Appeal based upon the information provided in the request. The Committee will work with the TPA and PBM to ensure that the benefits are being administered according to the contract between the Kentucky Employees Health Plan and the TPA or PBM. Once a determination is made, the Administrative Appeal Committee will notify the member in writing of its decision. The committee will consist of at least one individual from the Department for Employee Insurance, Kentucky Office of Insurance and the Cabinet for Health and Family Services.

Humana continues to partner with the **Commonwealth** for ***2007 healthcare benefits***

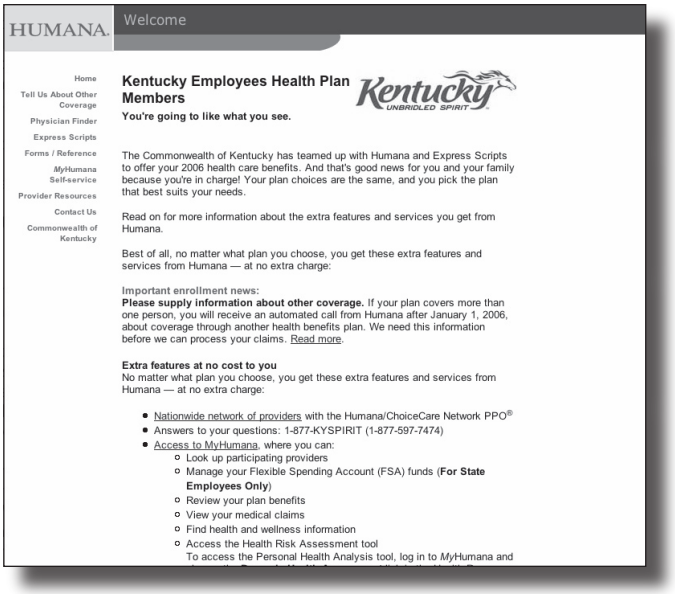
What's new for 2007

- Your choice of four medical plans, including a high deductible health plan – **Commonwealth Select** – that includes an expense account your employer puts money into called a Health Reimbursement Account (HRA). This plan option is in addition to **Commonwealth Premier**, **Commonwealth Enhanced**, and **Commonwealth Essential** plans.
- If you sign a **waiver of medical coverage**, choosing not to enroll in a medical plan option, you may be eligible to receive an HRA with carryover capabilities. The HRA will replace the FSA provided in prior plan years.

What stays the same

With any option you choose for 2007, you get the same 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. It's a nationwide network. So if you need medical care when traveling, or if you live outside of Kentucky, you'll have the opportunity to find an in-network provider nearby.
- **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)**. You'll receive personal attention from a representative dedicated exclusively to serving Kentucky Employees Health Plan members.
- **24-hour medical information** - HumanaFirst® is a toll-free health information line you can call to speak to a registered nurse about illnesses or injuries any time, day or night. This service is not intended for emergency situations. HumanaFirst also gives you access to an audio library of tapes that address more than 200 health topics.


HUMANA. Welcome

Home
Tell Us About Other Coverage
Physician Finder
Express Scripts
Forms / Reference
*My*Humana Self-service
Provider Resources
Contact Us
Commonwealth of Kentucky

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

Kentucky UNBRIDLED SPIRIT

The Commonwealth of Kentucky has teamed up with Humana and Express Scripts to offer your 2006 health care benefits. And that's good news for you and your family because you're in charge! Your plan choices are the same, and you pick the plan that best suits your needs.

Read on for more information about the extra features and services you get from Humana.

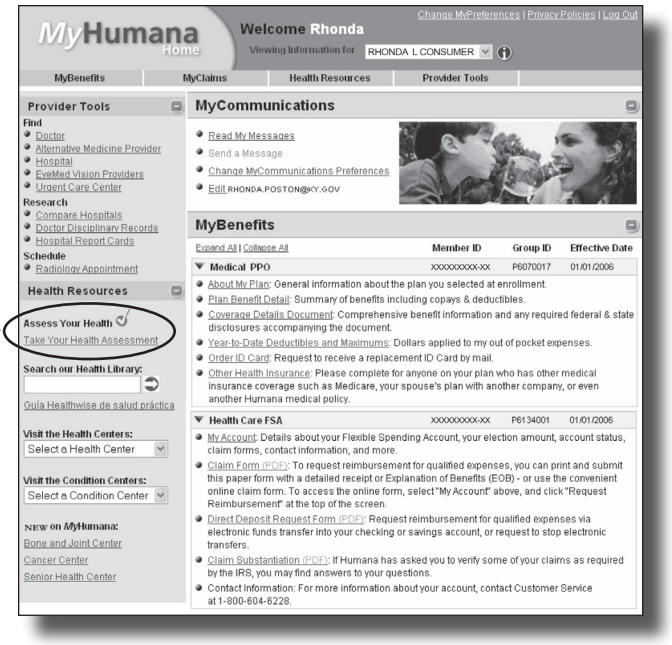
Best of all, no matter what plan you choose, you get these extra features and services from Humana — at no extra charge:

Important enrollment news:
Please supply information about other coverage. If your plan covers more than one person, you will receive an automated call from Humana after January 1, 2006, about coverage through another health benefits 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) funds (**For State Employees Only**)
  - Review your plan benefits
  - View your medical claims
  - Find health and wellness information
  - Access the Health Risk Assessment tool
    To access the Personal Health Analysis tool, log in to *My*Humana and

- **Custom Website** developed exclusively for the Kentucky Employees Health Plan members**.** After you've enrolled in an option, your benefits information and tools are as close as your computer. Simply log on to **kyhealthplan.humana.com** and register for *My*Humana, your personal, password-protected home page, to find the resources you need. Here are examples of what you can do at *My*Humana:
  - View your **medical claims** for up to 18 months
  - Take the **Health Risk Assessment** and print out the results
  - **Look up in-network doctors**, hospitals, urgent care and ambulatory care centers, pharmacies, and more
  - Manage your **Flexible Spending Account** (FSA) and **Health Reimbursement Account** (HRA) funds
  - Review a **Summary Plan Description**
  - Check out **Condition Centers** to learn about symptoms, treatments, and tests; track your condition; and print reports to discuss with your doctor
  - Create your own **health record**, including family history, immunizations, allergies, and medications



Here is where you can access the Health Risk Assessment tool.

  - Order replacement **ID cards**
  - Save money on medications, supplements, and other health and wellness products with the **Savings Center**
  - Use ***My*Financial Tools** to track what you've spent and find out how much a new procedure or prescription will cost.

- **Wellness and disease management programs.** A registered nurse works one-on-one with members as a health coach, providing education and resources to help members manage long-term medical conditions. Specific programs include:
  - **"Get Healthy" Wellness Programs** – health risk assessment and guidance for you and your family.
  - **Disease management programs** – designed to assist and educate members about managing their ongoing medical conditions.

We're here for you when you need us.

So be sure to take advantage of the year-round guidance and support Humana provides – at *your* convenience.

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

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

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 1483
  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 Health Plan, Inc.
Humana Insurance Company
Humana Insurance Company of Kentucky
Humana Medical Plan, Inc.

HUMANA®
Guidance when you need it most

Administered by Humana Insurance Company

GHC-13691 8/06

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®

ELIGIBILITY AND ENROLLMENT

Eligible Participants

FULL-TIME EMPLOYEES

Regular full-time employees of the following agencies who contribute to one of the state-sponsored retirement systems are eligible to participate:

- State Agencies
- Boards of Education
- Health Departments
- Members of additional groups whose employers pay into a state-sponsored retirement system and have elected to participate in the Kentucky Employees Health Plan (KEHP).

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)

OTHER ELIGIBLE PARTICIPANTS

Eligible COBRA participants.

LIMITATIONS

Employees, retirees, COBRA participants and their dependents may only be covered under **one** state-sponsored plan.

Eligible Dependents

DEPENDENT

Congress made changes to the definition of "dependent" for tax purposes, which may affect the eligibility of your dependents for your group health insurance coverage. Congress divided dependent into a "Qualifying Child" and a "Qualifying Relative".

For purposes of our health insurance Plan, a "Qualifying Child" is your child, stepchild, adopted child, foster child or grandchild, who lives with you for more than half of the taxable year, is less than 19 years of age at the end of the NEXT calendar year and for whom you will provide over ½ of his/her support during the calendar year.

- A foster child must have been placed by an authorized agency or by judgment, decree or court order.
- Adding a grandchild requires guardianship or custody papers.

- Temporary absences, such as for school, are permitted.
- Age restrictions do not apply to a child that is permanently and totally disabled.

For purposes of our health insurance Plan, a "Qualifying Relative" is your child, stepchild, adopted child, foster child or grandchild, who lives with you for more than half of the taxable year, is less than 24 years of age at the end of the NEXT calendar year and for whom you provide over ½ of his/her support. Adding a grandchild requires guardianship or custody papers.

For purposes of our health insurance Plan, a 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 the health care expenses of the child remains eligible for coverage as a "Qualifying Child" or "Qualifying Relative", depending on the child's age.

Dependents may only be covered under one (1) state sponsored plan. The employee with custody shall have first option to cover the dependent children, unless both employees agree otherwise in writing.

For purposes of our health insurance program, an unmarried disabled dependent may *continue* to be covered under the plan beyond the age limit if the disability started before the limiting age and is medically certified by a physician. A disabled dependent not covered under the plan prior to the limiting age due to coverage under other health insurance, may be enrolled in the KEHP if he/she loses the other health insurance coverage.

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 TPA may require proof of such dependent's disability no more than once a year. The TPA must approve total disability.

Levels of Coverage

Single – Covers the employee/retiree only
Parent Plus – Covers a married or single 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 health insurance application and turn it in to your agency's health 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).

Directing the Employer Contribution into a Health Reimbursement Account

If you waive the health insurance provided by the Commonwealth, you may be eligible to receive the employer contribution to direct into an HRA. The monthly contribution provided by the Commonwealth will be $175. **There are certain groups of individuals that are not eligible for participation in an HRA if they waive their health insurance.** Those individuals include, but are not limited to:

- Kentucky Retirement Systems retirees and Kentucky Teachers' Retirement System retirees
- Spouses of Hazardous Duty retirees that are active employees
- Retirees that have returned to work and are enrolled in a KEHP plan through their retirement system.

Directing Employee Funds into a Flexible Spending Account

If you are a state employee, a local board of education employee or an employee of certain quasi agencies, you are eligible to participate in the Commonwealth Choice Flexible Spending Account Program. During Open Enrollment, you may enroll online or by completing a paper application. In accordance to Federal guidelines, if you wish to contribute money to the Flexible Spending Account Program, you must enroll every year. **Enrollment is not automatic.**

If you are an **employee of any other agency**, you may be eligible to participate in a Flexible Spending Account program offered by your employer. Contact your agency's health Insurance Coordinator for more information.

If you are a retiree, you are not eligible to participate in the FSA programs.

STATE AND LOCAL BOARD OF EDUCATION EMPLOYEES – REFER TO THE FSA SECTION OF THIS HANDBOOK 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 Kentucky Employees Health Plan.

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 during the enrollment process 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 in 2007. Therefore, the Commonwealth Select Plan may not be selected by active employees who cross-reference with a retiree of the Kentucky Retirement Systems or the Kentucky Teachers' Retirement System.

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 regular family contribution**. Although the terminating employee is no longer eligible to receive an employer contribution, they have 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.

EFFECTIVE DATES

New Employees

Most employers participating in the KEHP will allow new employees thirty (30) calendar days from the date you are hired to:

- Enroll in a plan
- Enroll in a plan and enroll in a Health Care Flexible Spending Account (Optional). State employees, local school board employees and certain quasi agency employees must enroll online or by completing Sections I, VI and VIII of the health insurance 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 health insurance application and redirect the employer contribution into an HRA.

Applications are included in this Handbook and are available on the KEHP Web site at http://KEHP.ky.gov, or you may request an application from your agency's health Insurance Coordinator.

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 certain quasi agencies, 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 health Insurance Coordinator for details. **However, if your agency has a waiting period longer than the first day of the second calendar month, your online enrollment paper application must be signed at least thirty (30) calendar days prior to the coverage effective date.**

Open Enrollment

All elections made during Open Enrollment will be effective January 1, 2007.

Qualifying Events

Refer to pages 76-80 for information regarding Qualifying Event effective dates.

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 second month following the date in which your employment terminates. For example, if you terminate employment effective March 15, your health insurance coverage will terminate April 30. If you terminate employment effective March 31, your 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, 2006. 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).

Qualifying Events

Refer to pages 76-80 for information regarding Qualifying Event effective dates.

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 Plan 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.

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. Please 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 on the KEHP web site.

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 application is completed within the specified timeframe. Kentucky law requires that routine 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 and submitted to your Insurance Coordinator within sixty (60) calendar days from the date of birth.

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.

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 the appropriate form requesting a change.

Exceptions:

Adding a newborn only – employee has sixty (60) calendar days*
Adoption/Placement for adoption – 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 and sign the application or Dependent Add Form.

PRESIGNING

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.

**The effective dates of the indicated Qualifying Events are determined following the same guidelines as indicated under "Effective Dates" on page 74 of this section.*

- Presigning is allowed for **loss of group or other coverage** and for **gaining group coverage**.
- Effective dates are 1st day of 1st month after signature date.
- The effective date of the change to the plan must be consistent with the effective date of the event. In other words, we cannot make an effective date prior to the Qualifying Event date.
- If the Qualifying Event date is the 1st day of the month, employees may pre-sign during the previous month.

- If the Qualifying Event date **is any other day of the month**, the employee may pre-sign during **that month only**. This may create a gap in coverage.

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 the form. Complete, sign 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 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 date of insurance termination and persons who were covered by policy.

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

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.

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

- HIPAA certificate from prior carrier;
- Letter from employer/previous employer on letterhead identifying the date of insurance termination and persons who were covered by policy;
- Letter; 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.

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.

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 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 filed 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 page 70.

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.

Important Qualifying Event Facts

- The appropriate form must be completed and signed 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 health Insurance Coordinator or the Department for Employee Insurance's Member Services Branch for additional information regarding Qualifying Events.

HOW DO I KNOW WHICH FORM TO USE?

You should use the health insurance application for the following events:

- Initial enrollment at hire date (New Employee).
- 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 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 if:

- You are currently enrolled and you experience a Qualifying Event that allows you to add dependents to your plan with no other changes to your health insurance.

You should use the Dependent Drop Form if:

- You are currently enrolled and you experience a Qualifying Event that allows you to drop dependents from your plan with no other changes to your health insurance.

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
200 Fair Oaks Lane, Suite 501
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 health 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 grievance or 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 regulations, made by HIPAA, permits children born to, or placed for adoption with an employee during the period of COBRA continuation coverage, 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 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 or the General Notice will be mailed to employees by Ceridian COBRA Continuation Services immediately after the Insurance Coordinator enters the employees new hire information or COBRA Qualifying Event information on Ceridian's WebQE online information system.

TERMS YOU NEED TO KNOW

Adverse Determination
When a health plan reviews an admission, availability of care, continued stay or other health care 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 program pays in whole or in part, subject to any deductible, co-insurance or co-payment included in the program.

Balance Billing
If you use ***out-of-network*** benefits, you may be "balance billed" for any amount not paid by your insurance carrier or TPA. 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 co-insurance. Your insurance carrier or TPA's payment is made based on a fee schedule that would normally be used in Kentucky.

Co-insurance
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 insurance carrier or TPA. 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 PBA.

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 health plan. 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 health plan. 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 health care 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 health care of the Plan. As such, we will have a Third Party Administrator (TPA) 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.

Third Party Administrator (TPA)
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 insurance carrier or TPA.

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

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Health Insurance Portability and Accountability Act was passed by Congress in 1996. This law helps to protect an employee's right to health coverage during events such as changing or losing jobs, pregnancy, moving or divorce. It also provides rights and protections for employers when obtaining and renewing health coverage for their employees.

HIPAA and the Department for Employee Insurance

The HIPAA's Privacy Rules became effective April 14, 2003. These were issued to provide protection against the unauthorized use and disclosure of an individual's Protected Health Information (PHI). The Department for Employee Insurance is adhering to these rules in order to protect the confidentiality of our members. PHI is defined as information that can be identified as belonging to a specific individual. This information can be transmitted or maintained in many ways such as, but not limited to, mail, fax, copier, telephone, email or paper mediums. Disclosure of PHI to anyone other than the member is prohibited without the member's specific authorization to disclose.

Health Insurance and Health Flexible Spending information maintained by the Department for Employee Insurance may be disclosed to the member's spouse, dependent, or the member's legal counsel/representative if that member has completed an Authorization for Disclosure Form for the plan year and it has been received by the Department for Employee Insurance. If the member obtains legal counsel, the member will need to complete the Authorization for Disclosure Form and also provide a copy of the Letter of Representation authorizing the Department for Employee Insurance to correspond with the legal counsel. If the correct information is not provided to the Department for Employee Insurance, there will be no disclosure of information to anyone except the member. The Department for Employee Insurance will only provide information pertaining to eligibility, enrollment, disenrollment and Qualifying Events.

Authorization for Disclosure Forms are maintained by the Department for Employee Insurance for the plan year or until revoked by the member, whichever is shorter.

The member will need to contact the TPA for information relating to payment of claims and services. If the member needs to have information disclosed from the TPA to someone else, the TPA may require the member to complete its company's Authorization for Disclosure Form. The Authorization for Disclosure Form completed for the Department for Employee Insurance to disclose PHI will not be accepted by the TPA. The member will be required to abide by the TPA's policies and procedures concerning release of the member's PHI.

If you have any questions pertaining to HIPAA, please contact:

Department for Employee Insurance
Attn: HIPAA Privacy Officer
200 Fair Oaks Lane, Suite 501
Frankfort, KY 40601

IMPORTANT INFORMATION FOR RETIREES

THE 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 is being rolled out only for active employees in 2007. This will give the retirement systems time to analyze the plan for its potential benefit to retirees and to ensure statutory authority to offer this product, if it is deemed beneficial to their members.

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, please contact the retirement office for assistance before completing the application provided by the Retirement System. Contact information for each retirement system is listed below:

For **KCTCS Retirement** Benefits call (859) 246-3113.

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

For information on **Kentucky Retirement Systems**' insurance benefits, call 1-800-928-4646, 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 1-800-618-1687 or (502) 848-8500.

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, please 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 health care 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 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 (TPA) and Pharmacy Benefit Administrator (PBA) to its employees and retirees. Retirees are encouraged to contact Humana and Express Scripts, Inc. 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 application to the Personnel Cabinet, Department for Employee Insurance or directly to the TPA. 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 "Under Age-65 Memorandum" accompanying this Handbook.

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 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 would also apply 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
(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://personnel.ky.gov/stemp/dei/default.htm