COMMONWEALTH OF KENTUCKY

PRESCRIPTION DRUG

SUMMARY PLAN DESCRIPTION

COMMONWEALTH ENHANCED

EFFECTIVE JANUARY 1, 2008

TABLE OF CONTENTS

PLAN DESCRIPTION INFORMATION

1. Proper Name of Plan: Kentucky Employees Health Plan

   Common Name of Plan: Commonwealth of Kentucky

2. Plan Sponsor and *Employer*:

   Commonwealth of Kentucky
   Personnel Cabinet, Department for Employee Insurance
   501 High Street, Second Floor
   Frankfort, KY 40601
   (502) 564-0358

3. Plan Administrator and Named Fiduciary -

   Commonwealth of Kentucky
   Personnel Cabinet, Department for Employee Insurance
   501 High Street, Second Floor
   Frankfort, KY 40601
   (502) 564-0358

4. *Employer* Identification Number: 61-0600439

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

6. Plan benefits described in this booklet are effective January 1, 2008.

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

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

   Commonwealth of Kentucky
   Personnel Cabinet, Office of Legal Services
   501 High Street, Third Floor
   Frankfort, KY 40601
   (502) 564-7430

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

   Express Scripts, Inc.
   13900 Riverport Drive
   Maryland Heights, MO 63043
   Telephone: 877-597-7474

Plan Description Information Continued

10. This is a self-insured prescription benefit plan. The cost of the Plan is paid with contributions shared by the *employer* and *employee*. Benefits under the Plan are provided from the general assets of the *employer* and are used to fund payment of covered claims under the Plan plus administrative expenses.

11. Each *employee* of the *employer* who participates in the Plan has access to a Summary Plan Description, which is this booklet. This booklet will be available through the Personnel Cabinet's web site at http://kehp.ky.gov It contains information regarding the benefits provided and other Plan information.

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

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

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

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

16. This Plan is included in the Commonwealth of Kentucky Flexible Benefits Plan, a cafeteria plan created pursuant to the Internal Revenue Code, Subsection 125.

SCHEDULE OF PRESCRIPTION DRUG BENEFITS

RETAIL CO-PAYMENT STRUCTURE		
	In-network	Out-of-network
First tier co-payment per *prescription*	$5.00	30%
Second tier *co-payment* per *prescription*	$15.00*	30%
Third tier co-payment per prescription	$30.00*	30%
Retail *Prescription* Drug Maximum Supply	30 days	
MAIL ORDER and MAIL ORDER AT RETAIL PHARMACY CO-PAYMENT STRUCTURE		
First tier co-payment per *prescription*	$10.00	
Second tier *co-payment* per *prescription*	$30.00	
Third tier co-payment per prescription	$60.00	
Mail Order Drug Maximum Supply	90 days	

*After 75 prescriptions per individual or family per calendar year, the second tier co-payment will reduce by $5.00 and the third tier co-payment will reduce by $10. Prescriptions filled at mail order or mail order at a retail pharmacy do not apply toward the accumulation of 75 prescriptions.

ADDITIONAL PRESCRIPTION DRUG BENEFIT INFORMATION

If an *employee*/eligible *dependent* purchases a *brand name prescription*, and an equivalent *generic prescription* is available, the *employee*/eligible *dependent* must pay the difference between the *brand name prescription* and the *generic prescription* plus any applicable *brand prescription co-payment*. This is referred to as an ancillary fee. If the physician writes on the *prescription* "dispense as written", the drug will be dispensed as such, and the *employee*/eligible *dependent* will only be responsible for the *brand name prescription co-payment*.

The *Kentucky Employees Health Plan* utilizes Express Scripts 2008 National Preferred Formulary. As this formulary is subject to change throughout the year, you may request a copy by calling 877-597-7474 or by visiting Express Scripts' web site at www.express-scripts.com.

The *Kentucky Employees Health Plan* provides a benefit for certain over-the-counter (OTC) nicotine replacement therapies. This program requires active participation in an approved tobacco cessation program. Participants in this program will receive a benefit for these therapies at an appropriate co-payment.

SPECIALTY INJECTABLE DRUGS

The *Kentucky Employees Health Plan* utilizes *CuraScript* for specialty injectable drugs used to treat chronic conditions. *CuraScript* Pharmacy, a wholly owned subsidiary of Express Scripts, is a national provider of specialty pharmacy services offering a broad range of healthcare products and services for individuals with chronic health conditions such as, growth hormone deficiencies, hepatitis C, hemophilia, HIV/AIDS, cancer, multiple sclerosis, rheumatoid arthritis, and many others. *CuraScript* provides comprehensive patient management services including clinical case management programs, counseling, education, and social services. Medications will be ordered specifically for you and delivered to your home. *CuraScript* will allow for the first fill at any participating pharmacy. After the initial fill, all remaining medications must then be filled by *CuraScript*. *CuraScript* will handle everything about your specialty medications for you. A Patient Care Coordinator will work with you to ensure you receive the care you need. Your specialty drugs will be delivered to your home within a reasonable time, usually

within 24 hours. Included with your specialty drugs will be all your needed supplies – needles, syringes, alcohol swabs and sharps containers, at no additional cost to you.

CuraScript specializes in oral and injectable specialty medications. *CuraScript* offers many products and services that you do not get from other pharmacies. Most importantly, *CuraScript*:

- has a complete specialty pharmacy inventory with many specialty medications that are not readily available at a local pharmacy.
- delivers your specialty medications directly to you or your doctor.
- provides you with the necessary supplies you need to administer your medications — at no additional cost.
- offers clinically based care management programs — which include consultation with your doctor — to help you get the most benefit from the specialty medications that your doctor has prescribed for you.

Additional information, including a current listing of the drugs that must be purchased through *CuraScript* can be obtained by calling 877-597-7474.

STEP THERAPY

What is Step Therapy?

Step Therapy is a program especially for people who take prescription drugs regularly for an ongoing condition, such as arthritis, asthma, or high blood pressure. It provides the treatment you need while keeping your costs as low as possible.

How does it work?

The program moves you along a well-planned path, with your doctor approving your medications. Your path starts with “first-step” drugs — usually generic drugs proven to be safe and effective. You pay the lowest co-payment for these drugs. “Second-step” drugs, which are more expensive brand-name drugs, may be approved if medically necessary..

For example, with stomach ulcer step therapy, generic Prilosec is an example of a first-line drug that must be tried before a second-line drug such as Prevacid or Nexium. If you use a first-line prescription drug that does not work, a second-line drug may be approved for use. In some situations, a member may be granted a prior authorization for a second-line prescription drug if specific medical criteria have been met without the trial of a first-line prescription drug.

The Kentucky Employees Health Plan has contracted with Express Scripts to provide the Step Therapy. Express Scripts utilizes their guidelines and they work with your doctor to determine the most appropriate prescription drugs for you to use.

Break in Therapy

If you have been taking a drug that requires step therapy, and for any reason, the prescription drug is not filled within 130 days from the last fill, it will be considered a break in therapy and you must begin step therapy again, unless your doctor calls and receives prior authorization approval.

Examples of prescription drugs requiring Step Therapy:

Step Therapy Program	Medication
High Cholesterol	Lipitor, Caduet, Lescol, Lescol XL, Pravachol, Advicor, Altoprev, Crestor, Vytorin
High Blood Pressure	Lotrel, Altace, Lotensin, Avapro, Cozaar, Aceon, Vasotec, Benicar, Norvasc, Cardene SR, Sular, DynaCirc CR, Covera-HS, Veralan PM, Procardia XL, Plendil
Stomach Ulcers	Nexium, Prevacid, Prevacid SoluTab, Prilosec, Protonix, Aciphex, Zegerid
ADD/ADHD	Strattera
Antidepressants	Celexa, Effexor XR, Lexapro, Prozac, Sarafem, Paxil, Paxil CR, Zoloft
Topical Dermatitis	Protopic, Elidel
Asthma, COPD	Singulair, Accolate
Anti-inflammatory	Arthrotec, Mobic, Ponstel, Celebrex
Diabetes	Glucophage XR, Glumetza, Fortamet, Riomet

*****This list is not comprehensive or inclusive of all affected drugs.

- ***Please note that this list may change during the plan year.***

PRIOR AUTHORIZATION

Some drugs on the pharmacy benefit plan will need prior authorization, which means Express Scripts will need to make sure these prescriptions meet certain conditions for coverage. If authorized, the *prescription* drug will fall under the corresponding *co-payment* levels, and the prior authorization will be good for one year from the date of the prior authorization (with the exception of weight loss drugs). After the timeframe for the prior authorization is exhausted, your physician must call Express Scripts to request another prior authorization. If a *prescription* drug is not authorized, the *prescription* drug will not be covered.

Drugs requiring a prior authorization include, **but are not limited to**, the following:

- Adipex**
- Amevive
- Aralast
- Aranesp
- Buproban*
- Bontril**
- Botox (non-cosmetic)
- Didrex**
- Diethylpropion**
- Diflucan (excluding 150 mg tablet)
- Enbrel
- Epogen
- Fastin**
- Fluconazole (excluding 150 mg tablet)
- fluconazole powder
- Forteo
- Genotropin
- Genotropin Miniquick
- Geref
- Geref Diagnostic
- Humatrope
- Humira
- Ionamin**
- itraconazole 100 mg capsule
- Kineret
- Lamisil tablet
- Melfiat**
- Meridia**
- Myobloc
- Nicotrol*
- Norditropin
- Norditropin NordiFlex
- Nutropin
- Nutropin AQ
- Nutropin Depot
- Penlac 8% solution
- Phendimetrazine**
- phentermine**
- Prelu-2**
- Procrit
- Pro-fast**
- Prolastin
- Protropin
- Provigil
- Raptiva
- Regranex
- Remicade
- Retin-A
- Revatio
- Saizen
- Serostim
- Sporanox capsule
- Synagis
- Tazorac
- Tenuate**
- Tenuate dospan**
- Tev-tropin
- Topamax
- tretinoin
- Xenical**
- Xolair
- Zemaira
- Zonegran
- Zorbtive
- Zyban*

Please note that this list may change during the plan year.

* The Kentucky Employees Health Plan will cover the cost of certain smoking cessation drugs that require a written prescription to purchase. Your doctor must call for prior authorization for these prescriptions. The co-pay for these prescription drugs will be at the appropriate tier for a one (1) month supply and are not eligible for the maintenance drug program. Members will only receive a three (3) month supply each calendar year.

** The Kentucky Employees Health Plan will only cover these prescription drugs if the member is enrolled in the Why Weight Kentucky Program with Humana (Active*Health*). Why Weight Kentucky is a weight management program that is designed to assist you in achieving and maintaining a healthy weight. To qualify for the Why Weight Kentucky Program, you must have a Body Mass Index (BMI) of greater than thirty (30). For additional information regarding the Weight Management Program, call 1-877-597-7474.

Prior Authorization Hotline

The most efficient way to initiate a prior authorization review is to ask your physician to contact Express Script's prior authorization hotline at 800-241-1390. If the request is approved, an override code is provided for the pharmacist to enter and the claim is processed. If the request is not approved, a follow-up letter will be sent to the physician and the member.

Prior Authorization Form

Your physician may also fax a prior authorization form to Express Scripts for review. Prior authorization forms may be obtained by contacting Express Scripts at 877-KY-SPIRIT (877-597-7474). Prior authorization requests should be made by the physician or the pharmacist, if he or she has enough information..

To verify if a *prescription* drug requires *prior authorization*, call 877-597-7474 or visit the *Plan Manager's* web site at www.express-scripts.com.

QUANTITY LEVEL LIMITS (QLL)

Some *prescription* drugs may be subject to Quantity Level Limits (QLL). QLL will determine the monthly drug dosage dispensed and/or the number of months the drug usage is usually needed to treat a particular condition.

QLLs ensure that you receive the medication you need in the quantity that is considered safe, and the quantity that is recommended by the drug manufacturer, the U.S. Food & Drug Administration (FDA) and clinical studies.

How the program works:

At the pharmacy, you may be told that you are asking for a refill too soon; that is, you should still have some of your medication on hand. In this case, simply ask your pharmacist when you can get your next refill. If your prescription is written for a larger amount than your plan covers:

- You can ask your pharmacist to give you the amount that your plan covers. You will pay the appropriate co-payment each time.
- Or, your pharmacist can ask your doctor to change your prescription to a higher strength, when one is available. For instance, you might take one 40 mg pill instead of two 20 mg pills. This way, you meet your plan's quantity limit, you get the daily dose you need and you have fewer co-payments.
- Or, if your doctor doesn't agree with the limit, he or she can call Express Scripts to request a prior authorization, which may let you get a greater quantity.

Quantity limits can help you get the prescription drugs you need safely and affordably. To verify if a *prescription* drug is subject to *QLL*, call 877-597-7474 or visit the *Plan Manager's* web site at www.express-scripts.com.

PRESCRIPTION DRUG BENEFITS

RETAIL PHARMACY

Your Plan provisions include a retail *prescription* drug benefit. Your health insurance identification (ID) card will provide the information for you to present to your pharmacy.

Present your ID card at a *participating pharmacy* when purchasing a *prescription. Prescriptions* dispensed at a retail *pharmacy* are limited to a thirty (30) day supply per *prescription* or refill, except as provided under the Mail Order benefit below.

MAIL ORDER PHARMACY

Your *prescription* drug coverage also includes *mail order pharmacy* benefits allowing participants an easy and convenient way to obtain *prescription* drugs. If you have your prescription filled by the Express Scripts mail order pharmacy, your prescriptions will be shipped to your home address saving you time and money. Utilizing the mail order benefit will save you money by providing you a ninety (90) day supply of prescription drugs for the cost of a sixty (60) day supply.

Only prescription drugs classified as maintenance drugs, by the Plan, will be eligible for mail order pharmacy benefits.

Retail pharmacies may participate in the mail order benefit provided they meet the terms and conditions for participation established by Express Scripts, including price, dispensing fee and co-payment requirements of a mail order option. If your retail pharmacy participates in this benefit and your prescription drug is classified as a maintenance drug, by the plan, you will be able to receive the ninety (90) day supply for the cost of a sixty (60) day supply.

The mail order option shall not permit the dispensing of a controlled substance classified in Schedule II – either through Express Scripts mail order or the retail pharmacy offering mail order benefits.

In order for a prescription to qualify for the mail order option, you must have received one (1) thirty (30) day supply filled at the retail pharmacy or one ninety (90) day supply within the last six (6) months.

If you fill a ninety (90) day prescription (either at mail or retail) and for any reason it is more than 180 days from the date of the fill, you will not be allowed to fill that prescription by mail order without first having one (1) thirty (30) day supply filled again at retail.

Mail order pharmacy prescriptions will only be filled with the quantity prescribed by your physician and are limited to a maximum of a:

- 90 day supply per *prescription* or refill for a drug received from a *mail order pharmacy*; or
- 90 day supply per *prescription* or refill for *self-administered injectable medications* ; or
- 90 day supply per prescription or refill for a drug received from a retail pharmacy that has agreed to participate in the "mail order at retail" benefit. For a listing of participating pharmacies that will honor the mail order at retail, go to the Personnel Cabinet's web site at http://kehp.ky.gov.

Additional *mail order pharmacy* information can be obtained by calling 877-597-7474 or by visiting the *Plan Manager's* web site at www.express-scripts.com.

NON-PARTICIPATING PHARMACY

Your pharmaceutical benefits are managed through a network of participating pharmacies. If you choose to fill a prescription at a non-participating pharmacy, you will be subject to the following guidelines.

When you use a *non-participating pharmacy*, you must pay the *pharmacy* the full price of the drug and submit the *pharmacy* receipt to Express Scripts at the address listed below. You will be responsible for any *prescription* cost differential between the cost of the *prescription* and the cost of the negotiated price *prescription* at a *participating pharmacy* after the charge has been reduced by the applicable *co-payment.*

You will have 180 days from the date the prescription is filled to file the prescription to Express Scripts.

Mail *pharmacy* receipts to:

Express Scripts
P. O. Box 66773
St. Louis MO 63166-6773
ATTN: Claims Department

PRESCRIPTION DRUG COST SHARING

Prescription drug benefits are payable for covered *prescription expenses incurred* by you or your covered *dependents*. Benefits for expenses made by a *pharmacy* are payable as shown on the Schedule of Prescription Drug Benefits.

You are responsible for payment of:

- The *co-payment;*
- The cost of medication not covered under the *prescription* drug benefit;
- The cost of any quantity of medication dispensed in excess of the day supply noted on the Schedule of Prescription Drug Benefits.

If the dispensing *pharmacy's* charge is less than the *co-payment*, you will be responsible for the lesser amount. The amount paid by the *Plan Manager* to the dispensing *pharmacy* may not reflect the ultimate cost to the *Plan Manager* for the drug. Your *co-payment* is made on a per *prescription* or refill basis and will not be adjusted if the *Plan Manager* or your *employer* receives any retrospective volume discounts or *prescription* drug rebates.

PRESCRIPTION DRUG COVERAGE

You must call 877-597-7474 or visit the *Plan Manager's* web site at www.express-scripts.com to verify whether a *prescription* drug is covered or not covered under the Plan.

Covered *prescription* drugs, medicine or medications must:

1. Be prescribed by a *physician* for the treatment of a covered *illness* or *bodily injury*; and

2. Be dispensed by a *pharmacist.*

Contrary to any other provisions of the Plan, *prescription* drug expenses covered under the Prescription Drug Benefit are not covered under any other provisions of the Plan. Any amount in excess of the maximum amount provided under the Prescription Drug Benefit is not covered under any other provision of the Plan. Any *expenses incurred* under provisions of the Prescription Drug Benefit section do not apply toward your medical deductible or out-of-pocket limits

The *Plan Manager* may decline coverage of a specific medication until the conclusion of a review period not to exceed six (6) months following FDA approval for the use and release of the drug, medicine or medication into the market.

Inherited Metabolic Diseases

Express Scripts will provide benefits for amino acid modified preparations and low-protein modified food products for the treatment of the following inherited metabolic diseases, if the amino acid modified preparations or low-protein modified food products are prescribed for therapeutic treatment and are administered under the direction of a physician, and are limited to the following conditions:

Phenylketonuria; Hyperphenylalaninemia; Tyrosinemia (types I, II, and III); Maple syrup urine disease; A-ketoacid dehydrogenase deficiency; 3-methylcrotonyl-CoA carboxylase deficiency; 3-methylglutacony1-CoA hydratase deficiency; 3-hydroxy-3-methylglutaryl-CoA lyase deficiency (HMG-CoA lyase deficiency); B-ketothiolase deficiency; Homocystinuria; Glutaric aciduria (types I and II); Lysinuric protein intolerance; Non-ketotic hyperglycinemia; Propionic academia; Gyrate atrophy; Hyperornithinemia/hyperammonemia/homocitrullinuria syndrome; Carbamoyl phosphate synthetase deficiency; Ornithine carbamoyl trasferase deficiency; Citrullinemia; Arginosuccinic aciduria; Methylmalonic academia; and Argininemia.

Coverage under this benefit is 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.

PRESCRIPTION DRUG EXCLUSIONS

Expenses incurred will not be payable for the following:

1. Any drug, medicine, medication or supply not approved for coverage under the Plan (call 877-597-7474 or visit the *Plan Manager's* web site at www.express-scripts.com to verify whether a *prescription* drug is covered or not covered under the Plan);
2. *Legend drugs* which are not recommended and not deemed necessary by a *physician*;
3. More than two fills for the same drug or therapeutic equivalent medication prescribed by one or more *physician* and dispensed by one or more retail *pharmacies*;
4. Charges for the administration or injection of any drug;
5. Drug delivery implants;
6. Any drug, medicine or medication labeled "Caution-Limited by Federal Law to Investigational Use," or experimental drug, medicine or medication, even though a charge is made to you;
7. Any drug, medicine or medication that is consumed or injected at the place where the *prescription* is given, or dispensed by the *physician*;
8. *Prescriptions* that are to be taken by or administered to the *covered person*, in whole or in part, while he or she is a patient in a facility where drugs are ordinarily provided by the facility on an inpatient basis. Inpatient facilities include, but are not limited to:
   a. *Hospital*;
   b. Skilled nursing facility; or
   c. Hospice facility;
9. Any drug prescribed for intended use other than for:
   a. Indications approved by the FDA; or
   b. Recognized off-label indications through peer-reviewed medical literature;
10. *Prescription* refills:
    a. In excess of the number specified by the *physician*; or
    b. Dispensed more than one year from the date of the original order;
11. Any drug for which a charge is customarily not made;
12. Therapeutic devices or appliances, including: hypodermic needles and syringes (except needles and syringes for use with insulin, and covered *self-administered injectable drugs*); support garments; test reagents; mechanical pumps for delivery of medication; and other non-medical substances, unless otherwise specified by the Plan;
13. Dietary supplements, nutritional products, fluoride supplements, minerals, herbs and vitamins (except pre-natal vitamins, including greater than one milligram of folic acid, and pediatric multi-vitamins with fluoride), unless otherwise specified by the Plan;
14. Injectable drugs, including but not limited to: immunizing agents; biological sera; blood; blood plasma; or *self-administered injectable drugs* not covered under the Plan;
15. Any drug prescribed for an *illness* or *bodily injury* not covered under this Plan, including, but not limited to sexual dysfunction;
16. Any portion of a *prescription* or refill that exceeds a thirty (30) day supply (or a ninety (90) day supply for a *prescription* or refill that is received from a *mail order pharmacy*);
17. Any portion of a *prescription* refill that exceeds the drug specific *dispensing limit*, is dispensed to a *covered person* whose age is outside the drug specific age limits, or exceeds the duration-specific *dispensing limit*, if applicable;
18. Any drug, medicine or medication received by the *covered person*:
    a. Before becoming covered under the Plan; or
    b. After the date the *covered person's* coverage under the Plan has ended;
19. Any costs related to the mailing, sending, or delivery of *prescription* drugs;
20. Any fraudulent misuse of this benefit including *prescriptions* purchased for consumption by someone other than the *covered person*;

21. *Prescription* or refill for drugs, medicines, or medications that are spilled, spoiled, or damaged;
22. Any drug or medicine that is:
    a. Lawfully obtainable without a *prescription* (over-the-counter drugs), except insulin; or
    b. Available in *prescription* strength without a *prescription*;
23. Any drug or biological that has received an "*orphan drug*" designation, unless approved by the Plan Administrator;
24. Any amount you paid for a *prescription* that has been filled, regardless of whether the *prescription* is revoked or changed due to adverse reaction or change in dosage or *prescription*;
25. More than one *prescription* within a 23-day period for the same drug or therapeutic equivalent medication prescribed by one or more *physician* and dispensed by one or more *pharmacies*, unless received from a *mail order pharmacy*. For drugs received from a *mail order pharmacy*, more than one *prescription* within a 20-day period for a 1-30 day supply; or a 60-day period for a 61-90 day supply. (Based on the dosage schedule prescribed by the *physician*).

In certain clinical situations, a Member may require use of a non-covered prescription drugs. This Plan has an Exceptions Policy that permits a Member to obtain a non-covered medication. If specific criteria are met, the Member can receive a non-covered drug. For more information regarding the exceptions policy, please call 877-597-7474.

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

Information regarding eligibility and enrollment, including COBRA is located in your Health Insurance Summary Plan Description (SPD). Please refer to that SPD for this information. To obtain a copy of your Health Insurance SPD, you may long on to Humana's web site at www.humana.com or the Personnel Cabinet's web site at http://kehp.ky.gov/**.**

CLAIM INFORMATION

NOTICE OF CLAIM

Written notice of claim must be given to the *Plan Manager* without delay, and no later than required by the Proof of Loss provision. Notice may be given to the *Plan Manager* as described in the How to File a Prescription Drug Claim section.

PROOF OF LOSS

You must give written proof of loss within 180 days after the date of loss, except if you were legally incapacitated.

HOW TO FILE A PRESCRIPTION DRUG CLAIM

You will receive an identification (ID) card which will contain information regarding your coverage. Present your ID card to the *pharmacy* to fill a *prescription*. You can mail your bill(s) to the *Plan Manager* at the address indicated below. Claim forms are available by calling 877-597-7474. Mail prescription drug claims to:

Express Scripts, Inc.
P. O. Box 66778
St. Louis, MO 63166-6773
ATTN: Claims Department

Be sure each prescription drug claim includes the patient name, *prescription* number, name of drug, name of *physician* and date filled and date purchased.

PAYMENT OF CLAIMS

The *Plan Manager* will make direct payment to the *pharmacy*, unless the *Plan Manager* is advised in writing that you have already paid the bill. If you have paid the bill, please indicate on the original statement, "paid by *employee*," and send it directly to the *Plan Manager*. You will receive a written explanation of the benefit determination. The *Plan Manager* reserves the right to request any information required to determine benefits or process a claim. You or the provider of *services* will be contacted if additional information is needed to process your claim.

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

Benefits payable on behalf of you or your covered *dependent* after death will be paid, at the Plan's option, to any *family member(s)* or your estate.

The *Plan Manager* will rely upon an affidavit to determine benefit payment, unless it receives written notice of valid claim before payment is made. The affidavit will release the Plan from further liability.

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

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

Coordination of Benefits

BENEFITS SUBJECT TO THIS PROVISION

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

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

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

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

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

EFFECT ON BENEFITS

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

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

ORDER OF BENEFIT DETERMINATION

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

1. The plan has no coordination of benefits provision;

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

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

Coordination of Benefits Continued

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

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

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

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

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

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

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

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

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

COORDINATION OF BENEFITS WITH MEDICARE

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

REIMBURSEMENT/SUBROGATION

RIGHT OF RECOVERY

These provisions apply when Plan benefits are paid as a result of injuries or illnesses *you* sustained and *you* have a right to a recovery or received a recovery.

SUBROGATION

This Plan reserves all rights of subrogation. This means that the Plan has the right to recover its previously paid benefit payments from any award, settlement, or damages that *you* or *your dependent* may receive or to which *you* may become entitled. It also means that the Plan has the right to take action on *your* behalf to obtain an award, settlement, or damages. The Plan shall have the first lien upon all awards, settlements, or damages subject to its subrogation or reimbursement rights listed below. This lien shall be

in the amount of benefits provided or the amount of benefits that will be provided under the Plan, plus the reasonable expenses, including attorneys' fees, to enforce the Plan's rights.

By accepting and in return for the payment of *covered expenses* by the Plan in accordance with the terms of this Plan, the beneficiary agrees to the following:

1. The Plan has the right to recover payments for benefits paid for by the Plan.

2. The Plan has the right to recover payment for benefits paid by the Plan to or on behalf of *you* or *your dependent* from any award, settlement, or damages that *you* or *your dependent* may become entitled to or receive as a result of an accident, a person's fault or negligence, or any other circumstance under which *you* or *your dependent* has the right to recover from any other party.

3. The Plan may recover its benefit payments for any type of benefit which may be paid by the Plan, such as medical, dental, vision, mental, disability, supplemental accident, or accidental death or dismemberment benefits.

4. An "award, settlement, or damages" includes any award, settlement, damages (whether equitable, legal, compensatory, etc.), compensation, benefits, or any other payment of any kind. The amount may be paid by formal court award, informal compromise, redemption agreement, application for benefits, or otherwise. The amount also may be paid in a lump sum, installment, or annuity payments (such as income replacement). The Plan has the right to recover from all of these amounts.

5. An "award, settlement, or damages" includes amounts of any type, kind, nature, or character, regardless of whether the amount identifies or covers the Plan's benefit payments, otherwise relates to medical benefits, or is specifically limited to certain kinds of damages or payments. In addition, attorneys' fees or any other costs associated with the amount will not reduce the amount of the Plan's reimbursement. This Plan has the first priority to recover from *your* award, settlement, or damages. The Plan's first priority lien also will apply regardless of whether *you* or *your dependent* is or was made whole from the award, settlement, or damages, whether before or after the Plan's subrogation recovery. This Plan precludes the operation of the "make-whole" and "common fund" doctrines.

Reimbursement/Subrogation Continued

6. *Your* "right to recover" from any other party means that *you* or *your dependent* has the right to recover damages or expenses from another party, such as an individual, partnership, corporation, government, or other entity, as well as against that party's respective insurance carriers or governmental fund, for causing an injury or illness to *you* or *your dependent* or otherwise with respect to any injury or illness incurred by *you* or *your* covered *dependent*. This right to recover from any other party also includes *your* own insurance carrier, such as *your* automobile insurance, automobile no-fault coverage, homeowners, personal accident, general liability, or life insurance carrier. It also includes a second medical insurance or other non-insured medical or other coverage. It also includes uninsured and underinsured motorist coverage or programs. The Plan has the right to recover from any of these parties, or any other parties, in connection with *your* illness or injury. In the event *you* or *your dependent* is entitled to or receives an award, settlement, or damages from any party (which includes the other party's or *your* own insurance carrier or coverage), the Plan has the first lien upon the award, settlement, or damages and must be reimbursed for its benefit payments made to *you* or *your dependent*, or on *your* behalf. The Plan's first lien supersedes any right that the Plan participant may have to be "made whole." In other words, the Plan is entitled to the right of first reimbursement out of any award, settlement, or damages the Plan participant procures or may be entitled to procure regardless of whether the Plan participant has received compensation for any of his or her damages or expenses, including any of his or her attorneys' fees or costs. Additionally, the Plan's right of first reimbursement will not be "set-off" or reduced for any reason, including attorneys' fees, costs, comparative negligence, limits of collectibility or responsibility, or otherwise. As a condition to receiving benefits under the Plan, the Plan participant agrees that acceptance of benefits is constructive notice of this provision. Reimbursement to the Plan must be made immediately upon entitlement or receipt of any award, settlement, or damages. The Plan will charge interest at a reasonable rate for any delay in reimbursement.

PLAN'S RIGHT TO ASSERT CLAIMS ON YOUR BEHALF

The Plan has the right, if it so chooses, to assert rights on *your* behalf to obtain an award, settlement, or damages. Specifically, through subrogation, the Plan is entitled to all claims, demands, actions, and rights of recovery which *you* or *your dependent* may have against or from any party to the extent of the Plan's benefit payments. In addition, this Plan is entitled to attorneys' fees incurred in asserting rights on *your* behalf. The Plan does not require *you* or *your dependent* to pursue a claim against another party. However, as stated above, the Plan reserves the right to directly pursue recovery against another party on *your* behalf, should *you* or *your dependent* elect not to pursue an award, settlement, or damages against or from a party.

MISCELLANEOUS SUBROGATION

You, *your dependent*, *your* attorneys, or anyone acting on *your* behalf legally cannot do anything to prejudice the rights of the Plan in the exercise of its subrogation rights to recover from, or assert *your* rights to obtain, an award, settlement, or damages. The Plan's subrogation rights also extend to the guardian or estate of *you* and *your dependent*. The Plan's subrogation provisions will apply without limitation by the Plan's Coordination of Benefits provisions, unless the Coordination of Benefits provisions would result in a greater recovery for the Plan.

Reimbursement/Subrogation Continued

DUTY TO COOPERATE

As a condition to participating in the Plan and receiving benefits under the Plan, *you* and *your dependent* agree to be bound by all of the Plan's provisions, including, but not limited to, the Plan's subrogation provisions. The Plan will make benefit payments on a claim on the condition that *you* or *your dependent*, upon entitlement or receipt of any award, settlement, or damages, will fully reimburse the Plan for the Plan's benefit payments and for expenses (including attorneys' fees and costs of suit, regardless of an action's outcome) incurred by the Plan in collecting this amount. As a precondition to receiving benefits under the Plan, *you* and *your dependent* must enter into agreement with the Plan to reimburse the Plan for its benefit payments from any award, settlement, or damages pursuant to the Plan's subrogation provisions. In this agreement, *you* also must agree to assign direct payment to the Plan from any award, settlement, or damages to the extent of the Plan's benefit payments. *You* and *your dependent* also otherwise must sign and deliver any and all instruments, papers, and reimbursement agreements required by the Plan necessary for the Plan's reimbursement right. *You* and *your dependent* also are required to do whatever is requested or necessary in order to fully execute and to fully protect all the Plan's rights and to do nothing that would interfere with or diminish those rights. Further, *you* and *your dependent* must notify the Plan in writing of any proposed settlement and obtain the Plan's written consent before signing any release or agreeing to any settlement. In any event, the Plan's benefit payments for any current or historical claims under the Plan on *your* behalf will be deemed to be the equivalent of *you* or *your* covered *dependent* entering into an agreement to reimburse the Plan and otherwise signing and delivering any instruments and papers as required by the Plan. In the event that *you* or *your dependent* fails to enter into the foregoing agreement, or to otherwise comply with such requests, the Plan is entitled to withhold or deny benefits otherwise due under the Plan until *you* do so.

RETENTION OF AN ATTORNEY

If *you* or *your* attorney receives any recovery (whether by award, settlement, damages, compromise, or otherwise), *you* have an absolute obligation to immediately tender the recovery to the Plan under the terms of this provision. If *you* or *your* attorney does not immediately tender the recovery to the Plan, *you* will be deemed to hold the recovery in constructive trust for the Plan, because *you* or *your* attorney is not the rightful owner of the recovery and should not be in possession of the recovery until the Plan has been fully reimbursed.

PARTICIPANT'S NONCOMPLIANCE

If *you* or *your dependent* do not comply with the provisions of this section, the Plan Administrator shall have the authority, at its sole discretion, to deny payment of any claims for benefits by *you* and to deny or reduce future benefits payable (including payment of future benefits for other injuries or illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, at its sole discretion, deny or reduce future benefits (including future benefits for other injuries or illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement. If the Plan must bring an action against *you* to enforce this provision, then *you* agree to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Reimbursement/Subrogation Continued

RIGHT TO COLLECT NEEDED INFORMATION

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

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

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

REIMBURSEMENT/SUBROGATION EXCLUSIONS

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

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

GENERAL PROVISIONS

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

CONTESTABILITY

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

RIGHT TO REQUEST OVERPAYMENTS

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

1. Made in error; or

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

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

WORKERS' COMPENSATION NOT AFFECTED

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

WORKERS' COMPENSATION

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

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

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

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

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

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

MEDICAID

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

If payment for Medicaid benefits has been made under a state Medicaid plan for which payment would

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

RIGHT OF RECOVERY

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

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

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

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

CONSTRUCTION OF PLAN TERMS

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

PRIVACY OF PROTECTED HEALTH INFORMATION

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

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

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

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

The *Plan Manager* will afford access to *protected health information* in its possession only as necessary to discharge its obligations as a service provider, within the restrictions noted above. However, Plan

records that include *protected health information* are the property of the Plan. Information received by the *Plan Manager* is information received on behalf of the Plan.

The *Plan Manager* will afford access to *protected health information* as reasonably directed in writing by the Plan Administrator, which shall only be made with due regard for confidentiality.

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

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

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

CLAIMS PROCEDURES

SUBMITTING A CLAIM

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

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

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

- Claims submissions must be timely. Claims must be filed as soon as reasonably possible after they are incurred, and in no event later than **180 days** after the date of loss, except if you were legally incapacitated. Plan benefits are only available for claims that are incurred by a *covered person* during the period that he or she is covered under the Plan.

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

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

Presentation of a *prescription* to a *pharmacy* does not constitute a claim. If a *covered person* is required to pay the cost of a covered *prescription* drug, however, he or she may submit a claim based on that amount to the *Plan Manager*.

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

Pharmacy claims and correspondence should be mailed to:

Express Scripts
P. O. Box 66773
St. Louis, MO 63166

PROCEDURAL DEFECTS

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

ASSIGNMENTS AND REPRESENTATIVES

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

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

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

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

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

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

CLAIMS DECISIONS

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

PRE-SERVICE CLAIMS

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

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

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

URGENT CARE CLAIMS

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

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

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

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

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

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

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

CONCURRENT CARE DECISIONS

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

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

POST-SERVICE CLAIMS

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

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

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

TIMES FOR DECISIONS

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

PAYMENT OF CLAIMS

Participating pharmacies will request an assignment of benefits as a matter of convenience to both provider and patient. Also as a matter of convenience, the *Plan Manager* will, in its sole discretion, assume that an assignment of benefits has been made to certain Network Providers. If you have paid the bill, please indicate on the original statement, "paid by *employee*," and send it directly to the *Plan Manager*. You will receive a written explanation of the benefit determination. The *Plan Manager* reserves the right to request any information required to determine benefits or process a claim. You or the provider of *services* will be contacted if additional information is needed to process your claim.

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

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

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

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

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

Appeals

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

1. **Adverse Determination** means when the Plan determines that procedures performed or proposed to be performed are not medically necessary or are considered experimental or investigational and therefore are denied, reduced or terminated. An Adverse Determination does not mean a determination that the healthcare services are not covered.

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

3. **Administrative Appeals** is for situations that do not fall in the category of either adverse determinations or coverage denials. For example, a member feels his/her cost should be reduced from what is determined by the plan (i.e., a drug is covered on the 3rd tier and the member feels the drug should be covered as a first or second tier co-pay).

Who performs the appeal?

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

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

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

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

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

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

Initial Complaint – a member should always contact the Third Party Administrator's Customer Service Department first (the number is located on the back of the ID card). Many problems can be resolved the same day. If not, the member services representative will investigate and contact the member with their

findings and any action taken to resolve the complaint. If a member's complaint is related to a denial of coverage or other decision by the Third Party Administrator, the member may file an appeal.

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

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

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

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

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

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

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

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

How to file an External Appeal– Adverse Determination

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

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

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

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

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

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

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

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

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

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

Coverage Denials

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

The Kentucky Office of Insurance may either overturn or uphold the decision of the internal appeal or they may allow an external review by an independent review entity (IRE) if a medical issue requires resolution.

Administrative Appeal for prescription drug changes

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

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

NOTICE OF PRIVACY PRACTICES (SUMMARY)

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

This Notice describes the obligations of the Department for Employee Insurance (DEI) and your legal rights regarding your Protected Health Information (PHI) under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Among other things, this Notice describes how your PHI may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law. This is a summary of DEI's Notice of Privacy Practices. For a complete Notice, please go to our web site at www.kehp.ky.gov or call our Member Services Branch at 888-581-8834.

The Kentucky Employees Health Plan (KEHP) is a self-funded governmental plan and, therefore, we are required to provide this Notice of Privacy Practice to you pursuant to HIPAA. DEI is the plan sponsor.

The HIPAA Privacy Rule protects only PHI. Generally, PHI is individually identifiable health information, including demographics information, collected from you or created or received by a health care provider, health care clearing house, or your employer on behalf of a group health plan that relates to: 1) your past, present, or future physical or mental health or condition; 2) the provisions or health care to you; or 3) past, present, or future payment for provisions of health care to you. **DEI does not maintain information regarding your specific medical condition but does maintain PHI related to demographic information and other information that is necessary for determining eligibility and enrollment in the KEHP**. If you have any questions about this Notice or about our Privacy Practices, please visit http://personnel.ky.gov/benefits/dei/hipaa.htm or contact Department for Employee Insurance, Attn; HIPAA Privacy Officer, 501 High Street, 2nd Floor, Frankfort, Kentucky 40601. The effective date of this Notice is January 1, 2008.

DEI Responsibilities

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

How DEI May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your PHI under certain circumstance without your permission. The following categories represent the different ways that we may use or disclose your protected health information: 1) **For Treatment;** 2) **For Payment;** 3) **For Health Care Operations;** 4) **To Business Associates;** 5) **As Required by Law;** 6) **To Avert a Serious Threat to Health or Safety;** 7) **To Plan Sponsors.**

Special Situations

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

Required Disclosures

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

Other Disclosures

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

Participant Rights

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

Complaints

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

IMPORTANT NOTICE
FROM THE KENTUCKY EMPLOYEES HEALTH PLAN
ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Kentucky Employees Health Plan (KEHP), and new prescription drug coverage available January 1, 2006 for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

1. **Starting January 1, 2006, new Medicare prescription drug coverage will be available to everyone with Medicare.**

2. **Pricewaterhouse Coopers (PwC) has determined that the prescription drug coverage offered by the Kentucky Employees Health Plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay.**

3. **Read this notice carefully - it explains the options you have under Medicare prescription drug coverage, and can help you decide whether or not you want to enroll.**

You may have heard about Medicare's new prescription drug coverage, and wondered how it would affect you. PwC has determined that your prescription drug coverage with the KEHP is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay.

Starting January 1, 2006, prescription drug coverage will be available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans will provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium.

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare coverage.

People with Medicare can enroll in a Medicare prescription drug plan from November 15, 2005 through May 15, 2006. However, because you have existing prescription drug coverage that, on average, is as good as Medicare coverage, you can choose to join a Medicare prescription drug plan later. Each year after that, you will have the opportunity to enroll in a Medicare prescription drug plan between November 15th through December 31st.

If you do decide to enroll in a Medicare prescription drug plan and drop your KEHP prescription drug coverage, be aware that you may not be able to get this coverage back.

If you drop your coverage with the KEHP and enroll in a Medicare prescription drug plan, you may not be able to get this coverage back later. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

In addition, your current coverage pays for other health expenses, in addition to prescription drugs, and you will still be eligible to receive all of you current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan.

You should also know that if you drop or lose your coverage with the KEHP and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more to enroll in Medicare prescription drug coverage later. If after May 15, 2006, you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage; your monthly premium will go up at least 1% per month for every month after May 15, 2006 that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare coverage. In addition, you may have to wait until next November to enroll.

For more information about this notice or your current prescription drug coverage…

Contact our office for further information at 888-581-8834. NOTE: You may receive this notice at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage…

More detailed information about Medicare plans that offer prescription drug coverage will be available in October 2005 in the "Medicare & You 2006" handbook. You'll get a copy of the handbook in the mail from Medicare. You may also be contacted directly by Medicare prescription drug plans. You can also get more information about Medicare prescription drug plans from these places:

- Visit www.medicare.gov for personalized help,
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number)
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage after May 15, 2006, you may need to give a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Date:	January 1, 2008
Name of Entity/Sender:	Department for Employee Insurance
Address:	501 High Street, 2nd Floor, Frankfort, Kentucky 40601
Phone Number:	888-581-8834

DEFINITIONS

Ancillary Charge – a charge in addition to the co-payment which the member is required to pay a Participating Pharmacy for a covered brand name prescription drug product for which a generic substitute is available as identified on the Maximum Reimbursement Amount ("MRA") List. The Ancillary Charge is calculated as the difference between the Client Contract Rate for the brand name prescription product dispensed and the price of the generic substitute.

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

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

Brand name medication means a medication that is manufactured and distributed by only one pharmaceutical manufacturer, or as defined by the national pricing standard used by the *Plan Manager*.

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

Chemical Equivalents – multi-source drug products containing essentially identical amounts of the same active ingredients, in equivalent dosage forms, and meet existing FDA physical/chemical standards.

Compound drugs – a drug prepared by a pharmacist using a combination of drugs in which as least one agent is a legend drug. The final product is typically not commercially available in the strength and/or dosage form prescribed by the physician.

Concurrent DUR – on-line, real time edits using the claims database to help identify potential drug-related problems. Alerts are transmitted from Express Scripts to the dispensing pharmacist at a participating pharmacy (retail and mail) and allow Express Scripts to document the intervention and outcomes that occur. Concurrent DUR modules available include edits for drug-drug interactions, maximum daily dose, therapeutic/ingredient duplication, drug-age management, drug protocol management by gender, and other relevant drug-related problems. These edits should not be confused with numerous other edits in the Express Scripts system to limit days supply, early refill requests, quantity per day limit.

Co-payment means the amount to be paid by you toward the cost of each separate *prescription* order or refill of a covered drug when dispensed by a *participating pharmacy*.

Covered expense means *services* incurred by you or your covered *dependents* due to *bodily injury* or *illness* for which benefits may be available under the Plan. *Covered expenses* are subject to all provisions of the Plan, including the limitations and exclusions.

Covered person means the *employee* or any of the *employee's* covered *dependents*.

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

Definitions Continued

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

1. An *employee's spouse* under an existing legal marriage;

2. A *member's* unmarried *dependent* child.

KEHP *dependent* child eligibility rules

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

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

Temporary absences, such as for school, are permitted.

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

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

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

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

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

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

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

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

Working Families Tax Relief Act (WFTRA) of 2004

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

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

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

A "qualifying child" (QC) is a child who:

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

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

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

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

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

A person cannot be a "qualifying relative" of the *member* if at any time during the taxable year the relationship between the *member* and the person violates federal, state, or local law.

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

IMPORTANT: I.R.C. § 152 does not change KEHP's eligibility rules. It does not create any new category of eligible *dependents*, or make people who were previously ineligible for coverage now eligible. It simply redefines the way the IRS treats *dependent* children age 24 and over for tax purposes only. A *dependent* shall meet KEHP's eligibility rules before an employee may add the *dependent* to the Plan. **Adding a *dependent* to the Plan who does not meet the KEHP eligibility rules may be considered insurance fraud. Paying *dependent* premiums on a pre-tax basis for an individual who does not meet the definition of "qualifying child" or "qualifying relative" may be in violation of federal tax law.**

Dispense as Written (DAW) – a physician directive not to substitute a product.

Drug list means a list of drug products, approved by the *Plan Manager*, that are available for use by you.

Employee means you, as an *employee*, when you are permanently employed and paid a salary or earnings

and are in an *active status* at your *employer's* place of business.

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

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

Express Scripts CuraScript program – a specialty pharmacy management program specializing in the provision of high-cost biotech and other drugs used to treat long-term chronic disease states via CuraScript pharmacy.

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

Generic medication means a drug that is manufactured, distributed and available from several pharmaceutical manufacturers and identified by the chemical name; or as defined by the national pricing standard used by the *Plan Manager*.

Illness – means a disturbance in function or structure of your body which causes physical signs or symptoms and which, if left untreated, will result in a deterioration of the health state of the structure or system(s) of your body.

Late applicant means an *employee* and/or an *employee's* eligible *dependent* who applies for prescription drug coverage more than 30 days after the eligibility date.

Legend drug means any medicinal substance the label of which, under the Federal Food, Drug and Cosmetic Act, is required to bear the legend: Caution: Federal Law Prohibits dispensing without *prescription*.

Level 1 drugs means a category of *prescription* drugs, medicines or medications within the *Plan Manager's drug list* that are designated by the *Plan Manager* as *level 1 drugs*.

Level 2 drugs means a category of *prescription* drugs, medicines or medications within the *Plan Manager's drug list* that are designated by the *Plan Manager* as *level 2 drugs*.

Level 3 drugs means a category of *prescription* drugs, medicines or medications within the *Plan Manager's drug list* that are designated by the *Plan Manager* as *level 3 drugs*.

Maintenance medication means *prescription* drugs, medicines or medications that are:

1. Generally prescribed for treatment of long-term chronic *illness* or *bodily injuries*; and

2. Purchased from the *pharmacy* contracted by the *Plan Manager* to dispense drugs.

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

Multi source brand – means a drug sold/marketed by two or more manufacturers or labelers.

National Drug Code (NDC) – a national classification system for identification of drugs. Similar to the Universal Product Code (UPC).

Non-participating pharmacy means a *pharmacy* which has not entered into an agreement with the *Plan Manager* to participate as part of the Express Scripts Pharmacy Network.

Over-the-Counter (OTC) drug – a drug product that does not require a Prescription Order under federal or state law.

Participating pharmacy means a *pharmacy* which has entered into an agreement to participate as part of the Express Scripts Pharmacy Network to dispense covered drugs to you and your covered *dependents* and to accept as payment the *co-payment* amount to be paid by you and the amount of the benefit payment provided by the Plan.

Pharmacist means a person who is licensed to prepare, compound and dispense medication and who is practicing within the scope of his or her license.

Pharmacy means a licensed establishment where *prescription* medications are dispensed by a *pharmacist*.

Plan Manager means Express Scripts. The *Plan Manager* provides services to the Plan Administrator, as defined under the Plan Management Agreement. The *Plan Manager* is not the Plan Administrator or the Plan Sponsor.

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

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

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

Prescription means a direct order for the preparation and use of drug, medicine or medication. The drug, medicine or medication must be obtainable only by *prescription*. The order must be given verbally or in writing by a *physician* (prescriber) to a *pharmacist* for the benefit of and use by a *covered person*. The *prescription* must include:

1. The name and address of the *covered person* for whom the *prescription* is intended;

2. The type and quantity of the drug, medicine or medication prescribed, and the directions for its use;

3. The date the *prescription* was prescribed; and

4. The name, address and DEA number of the prescribing *physician.*

Prior authorization (PA) – the *process of obtaining certification of coverage for certain Prescription Drug Products, prior to their dispensing*.

Qualified medical child support order means a state court order or judgment, including approval of a settlement agreement which:

1. Provides for support of a covered *employee's* child;

2. Provides for health benefit coverage to the child;

3. Is made under state domestic relations law;

4. Relates to benefits under this Plan; and

5. Is qualified in that it meets the technical requirements of ERISA or applicable state law.

It also means a state court order or judgment that enforces a state Medicaid law regarding medical child support required by the Omnibus Budget Reconciliation Act of 1993.

Quantity Level Limit – means coverage of selected drugs covered under the Plan are limited to specified values over a set period of time. These values include, but are not limited to, drug quantity, day supply, number of refills and sponsor paid dollars.

Self-administered injectable drug means an FDA approved medication which a person may administer to himself/herself by means of intramuscular, intravenous, or subcutaneous injection, and intended for use by you.

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

Single source brand – a drug that is available from only one source, usually the innovator that invented it. These drugs are patent protected brand name drugs for which no generic exists.

Therapeutic Equivalent – a medication that can be expected to have the same clinical effect and safety profile when administered under the conditions specified in labeling as another medication, although the medications are not chemical equivalents.

Timely applicant means an *employee* and/or an *employee's* eligible *dependent* who applies for prescription drug coverage within 31 days of the eligibility date.

Total disability *or* ***totally disabled*** means:

1. During the first twelve months of disability you or your employed covered spouse are at all times prevented by *bodily injury* or *illness* from performing each and every material duty of your respective job or occupation;

2. After the first twelve months, *total disability* or *totally disabled* means that you or your employed covered spouse are at all times prevented by *bodily injury* or *illness* from engaging in any job or occupation for wage or profit for which you or your employed covered spouse are reasonably qualified by education, training or experience;

3. For a non-employed spouse or a child, *total disability* or *totally disabled* means the inability to perform the normal activities of a person of similar age and gender.

A *totally disabled* person also may not engage in any job or occupation for wage or profit.

Unit Dose Medications – medications packaged in individual unit-of-use blister packs. Unit dose medications tend to be more expensive. Pharmacies providing medications to long-term care facilities are often required to dispense in unit dose packaging.