

**KENTUCKY EMPLOYEES
HEALTH PLAN**

COMMONWEALTH OF KENTUCKY

**COMMONWEALTH CAPITOL CHOICE
SUMMARY PLAN DESCRIPTION**

GROUP NUMBERS: P5941, P6070 AND P6077

EFFECTIVE JANUARY 1, 2009

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PLAN DESCRIPTION INFORMATION

1. Proper Name of *Plan*: Kentucky Employees Health Plan
Common Name of *Plan*: Commonwealth of Kentucky
2. Plan Sponsor and *Employer*: Commonwealth of Kentucky
Personnel Cabinet, Department of Employee Insurance
501 High Street
Second Floor
Frankfort, Kentucky 40601
3. Plan Administrator and Named Fiduciary:

Commonwealth of Kentucky
Personnel Cabinet, Department of Employee Insurance
501 High Street
Second Floor
Frankfort, Kentucky 40601
4. *Employer* Identification Number: 61-0600439.
5. The *Plan* provides medical benefits for participating *employees* and their enrolled *dependents*.
6. *Plan* benefits described in this booklet are effective January 1, 2009.
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, Kentucky 40601
9. The *Plan Manager* is responsible for performing certain delegated administrative duties, including the processing of *claims*. The *Plan Manager* and Claim Fiduciary is:

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

Plan Description Information Continued

10. This is a self-insured health benefit *plan*. The cost of the *Plan* is paid with contributions shared by the *employer* and *employee*. Benefits under the *Plan* are provided from the general assets of the *employer* and are used to fund payment of covered *claims* under the *Plan* plus administrative expenses. Please see *your employer* for the method of calculating contributions and the funding mechanism used for the accumulation of assets through which benefits are provided under this *Plan*.
11. Each *employee* of the *employer* who participates in the *Plan* has access to a *Summary Plan Description*, which is this booklet. This booklet will be available through MyHumana.com or <http://kehpk.y.gov>. It contains information regarding eligibility requirements, termination provisions, a description of the benefits provided and other *Plan* information. Changes can occur to the Summary Plan Description throughout the year. Such changes will be posted to the KEHP web site listed above.
12. The *Plan* benefits and/or contributions may be modified or amended from time to time, or may be terminated at any time by the Plan Sponsor. Significant changes to the *Plan*, including termination, will be communicated to participants as required by applicable law.
13. Upon termination of the *Plan*, the rights of the participants to benefits are limited to *claims* incurred and payable by the *Plan* up to the date of termination. *Plan* assets, if any, will be allocated and disposed of for the exclusive benefit of the participating *employees* and their *dependents* covered by the *Plan*, except that any taxes and administration expenses may be made from the *Plan* assets.
14. The *Plan* does not constitute a contract between the *employer* and any *covered person* and will not be considered as an inducement or condition of the employment of any *employee*. Nothing in the *Plan* will give any *employee* the right to be retained in the service of the *employer*, or for the *employer* to discharge any *employee* at any time.
15. This *Plan* is not in lieu of and does not affect any requirement for coverage by Workers' Compensation insurance.
16. This *Plan* is included in the Commonwealth of Kentucky Flexible Benefits Plan, a Cafeteria Plan created pursuant to the Internal Revenue Code Subsection 125.

YOUR RIGHTS AND RESPONSIBILITIES

<p>As a Humana plan member, you have the right to:</p> <ul style="list-style-type: none"> • Be provided with information about the Humana <i>plan</i>, its <i>services</i> and benefits, its <i>providers</i>, and <i>your member</i> rights and responsibilities. • Privacy and confidentiality regarding <i>your</i> medical care and records. Records pertaining to <i>your</i> health care will not be released without <i>your</i> or <i>your</i> authorized representative's written permission, except as required by law. • Discuss <i>your</i> medical record with <i>your physician</i>, and receive upon request a copy of that record. • Be informed of <i>your</i> diagnosis, treatment choices, including non-treatment, and prognosis in terms <i>you</i> can reasonably expect to understand, and to participate in decision-making about <i>your</i> health care and treatment plan. • Have a candid discussion with <i>your</i> practitioner about appropriate or <i>medically necessary</i> treatment options for <i>your</i> conditions, regardless of cost or benefit coverage. • Expect reasonable access to <i>medically necessary</i> health care <i>services</i> regardless of race, national origin, religion, physical abilities, or source of payment. • File a formal complaint, as outlined in the <i>plan's</i> grievance procedure, and to expect a response to that complaint within a reasonable period of time. • Be treated with courtesy and respect, with appreciation for <i>your</i> dignity and protection of <i>your</i> right to privacy. • Make recommendations regarding the <i>Plan's</i> "rights and responsibilities" policies. 	<p>You also have the responsibility to:</p> <ul style="list-style-type: none"> • Give the Humana <i>Plan</i> and <i>your</i> health care <i>provider</i> complete and accurate information needed in order to care for <i>you</i>. • Read and be aware of all material distributed by the <i>plan</i> explaining policies and procedures regarding <i>services</i> and benefits. • Obtain and carefully consider all information <i>you</i> may need or desire in order to give informed consent for a procedure or treatment. • Follow the treatment plan agreed on with <i>your</i> health care <i>provider</i>, and to weigh the potential consequences of any refusal to observe those instructions or recommendations. • Be considerate and cooperative in dealing with the <i>plan providers</i> and to respect the rights of fellow <i>plan members</i>. • Schedule appointments, arrive on time for scheduled visits, and notify <i>your</i> health care <i>provider</i> if <i>you</i> must cancel or be late for a scheduled appointment. • Express opinions, concerns, or complaints in a constructive manner. • Notify the Plan Sponsor in writing if <i>you</i> move or change <i>your</i> address or phone number, even if these changes are only temporary. • Pay all <i>copayments</i>, coinsurance and/or <i>premiums</i> by the date when they are due. • Be honest and open with <i>your physician</i> and report unexpected changes in <i>your</i> condition in a timely fashion. • Follow health care facility rules and regulations affecting patient care and conduct.
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<p>As a Humana <i>plan member</i>, you have the right to:</p> <ul style="list-style-type: none"> • Receive Humana’s Notice of Privacy Practices. • Expect <i>your</i> personal information to be kept secure and used appropriately for payment and health plan operations. • Expect Humana to adhere to all privacy and confidentiality policies and procedures. • Expect the following activities concerning <i>your</i> personal information: <ul style="list-style-type: none"> ➤ Request an accounting of disclosures of personal health information disclosed for reasons outside of payment and health plan operations. ➤ Receive an authorization form for any proposed use of <i>your</i> personal health information outside of routine payment and health plan operations. ➤ Request an alternate form of communication of personal health information if the release of a portion or all of the information could endanger life or health. ➤ Right to complain regarding an alleged breach of privacy. ➤ Right to agree or object regarding Humana’s intent to release <i>your</i> personal information outside of payment or health plan operations. ➤ Right to request an amendment or correction of <i>your</i> personal information to a designated record created by Humana. ➤ Right to request access to inspect and copy information. 	<p>You also have the responsibility to:</p> <ul style="list-style-type: none"> • Carry <i>your</i> Humana identification card with <i>you</i> at all times and use it while enrolled in the Humana <i>Plan</i>.
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As a Humana *plan member*, you have the right to:

- Expect the following activities concerning *your* personal information continued:
 - Right to request Humana to restrict the use and disclosure of *your* personal information and the right to terminate the restriction request.

SCHEDULE OF BENEFITS

AN IMPORTANT MESSAGE ABOUT YOUR PLAN

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

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

PRECERTIFICATION

Precertification will be performed by the *Plan Manager*. Refer to *your* ID card for the appropriate phone number for *your* provider to call for *precertification*. Certain *services* may still require *precertification* by your *qualified practitioner*. Check with your *qualified practitioner* or Humana before *services* are performed.

PREFERRED PROVIDER AND FACILITY PLAN OPTION

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

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

If *you* choose to receive *your* medical care from a Preferred *Provider*, *services* are payable as shown on the Schedule of Benefits. Office exams are subject to a \$15 *copayment* per visit as shown on the Schedule of Benefits. The *copayment* does not apply to the *coinsurance* or *out-of-pocket limits* shown on the Schedule of Benefits. *Copayment* includes all *services* performed on the same day/same site as office visit.

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

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

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

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

Schedule of Benefits Continued

MYHUMANA

MyHumana is a personal, password-protected home page that provides information and tools to help *covered persons* make informed decisions. Log in to *MyHumana*, at www.humana.com, anytime to find a participating provider, look up benefits or check the status of a claim. *You* can also find shop-and-compare tools to help *you* choose *hospitals* and doctors, a health encyclopedia, information on specific health conditions, financial tools to help with budgeting for health care and more.

HUMANA HEALTH ASSESSMENT

The Health Assessment is a confidential, online lifestyle questionnaire located at *MyHumana* (accessible at www.humana.com). Upon completion of the assessment, *you* will receive a customized health report that identifies health risks and provides steps *you* can take to gain more control of *your* health. Responses may also result in a referral to an Informed Care Management Program.

PARTICIPATING PROVIDER BENEFIT ALLOWANCE

This Plan contains a Participating Provider Benefit Allowance (PAR Benefit Allowance). This allowance applies to the first \$500 of *covered expenses* for *medically necessary services* (excluding pharmacy *services*) received from *participating providers* per *covered person* per *calendar year*. Benefits provided under this allowance are not subject to the annual *deductibles* shown on the Schedule of Benefits and are payable at 100% after any applicable *copayments* or *coinsurance*. The PAR Benefit Allowance does not apply to *non-participating providers*, *copayments*, *prescription drug* benefits, or routine care benefits.

Covered expenses for *medically necessary services* received from *PAR providers* provided under this allowance do not accumulate towards the Plan *out-of-pocket limits*.

Once the total amount of *covered expenses* for *medically necessary services* received from *participating providers* exceeds the above stated allowance, any additional *covered expenses* for *medically necessary services* from *participating providers* will be subject to the annual *deductibles* and payable at the benefit levels shown in the Schedule of Benefits. Any unused amount of the PAR Benefit allowance does not carry over into the next *calendar year*.

Schedule of Benefits Continued

MEDICAL DEDUCTIBLE AND COINSURANCE INFORMATION		
Lifetime Maximum	Unlimited	
BENEFIT	PAR PROVIDER (IN-NETWORK)	NON-PAR PROVIDER (OUT-OF-NETWORK)
<i>Deductible:</i>		
Individual	\$ 500	\$1,000
Family	\$1,500 embedded	\$3,000 embedded
<p>If you have more than one family member covered under your plan, one family member may satisfy the individual \$500 deductible and the remaining \$1,000 family deductible may be met by any combination of the remaining family member's claims up to the \$1,500 family deductible maximum. Here are the deductible rules:</p> <ul style="list-style-type: none"> • No single family member will pay more than \$500 in deductible; • No single family member can contribute more than \$500 to the family deductible maximum; and, • Of the \$1,500 family maximum deductible, \$500 can be met by a family member and the remaining \$1,000 can be met by a combination of additional family members or, • All family members' services can be combined and applied to meet the family \$1,500 deductible. • If only two family members are covered under this Plan (employee and spouse or employee and one child), each covered member will have a \$500 deductible. You will not have to satisfy the family deductible. 		
<i>Coinsurance</i>	80% (you pay 20%)	60% (you pay 40%)
<i>Out-of-Pocket Limit:</i> (Includes Deductible)		
Individual	\$2,000	\$ 4,000
Family	\$6,000	\$12,000
<p>When the amount of combined covered expenses paid by you and/or all your covered dependents satisfy the out-of-pocket limits, including the deductible as shown on the Schedule of Benefits, the Plan will pay 100% of covered expenses for the remainder of the calendar year, unless specifically indicated, subject to any calendar year maximums of the Plan. Copayments will continue to be the responsibility of the covered person.</p> <p>If only two family members are covered under this Plan (employee and spouse or employee and one child), each covered member will satisfy the individual out-of-pocket limit. You will not have to satisfy the family out-of-pocket limit.</p> <p>If you and your covered dependents use a combination of PAR and Non-PAR providers, the PAR and Non-PAR deductible amounts will reduce each other.</p> <p>If you and your covered dependents use a combination of PAR and Non-PAR providers, the PAR and Non-PAR out-of-pocket amounts will reduce each other.</p> <p>If you or your covered dependents use a Non-PAR provider, the Plan Manager's reimbursement will be payable on a maximum allowable fee basis. Any amounts above the maximum allowable fee will be the member's responsibility and will NOT apply to the out-of-pocket limit.</p>		

Schedule of Benefits Continued

MEDICAL COVERED EXPENSES		
BENEFIT	PAR PROVIDER (IN-NETWORK)	NON-PAR PROVIDER* (OUT-OF-NETWORK)
<i>Inpatient Hospital</i>	Subject to a \$100 <i>copayment</i> per admission, then <i>deductible</i> and payable at 100%.	Subject to <i>deductible</i> and <i>coinsurance</i> .
<u>Outpatient Facility</u>		
<i>Outpatient Hospital</i>	Subject to a \$50 <i>copayment</i> per visit, then <i>deductible</i> and payable at 100%.	Subject to <i>deductible</i> and <i>coinsurance</i> .
<i>Outpatient Diagnostic X-ray and Lab</i>	Subject to <i>deductible</i> and <i>coinsurance</i> .	Subject to <i>deductible</i> and <i>coinsurance</i> .
Pre-admission Testing	Payable at 100%.	Payable at 100%.
<i>Emergency Room Facility</i>	Subject to a \$100 <i>copayment</i> per visit, then <i>deductible</i> and payable at 100%.	Payable same as PAR Provider Benefit.
<i>Emergency Room Ancillary</i>	Subject to <i>deductible</i> and payable at 100%.	Payable same as PAR Provider Benefit.
<i>Emergency Room Physician</i>	Subject to <i>deductible</i> and payable at 100%.	Payable same as PAR Provider Benefit.
	True <i>emergency</i> care provided by a <i>Non-PAR</i> provider will be covered at the <i>PAR</i> provider level. The <i>emergency</i> room <i>copayment</i> will be waived if you are admitted. However, you will have a \$100 in-hospital <i>copayment</i> .	
<i>Free Standing Surgical Facility</i>	Subject to a \$50 <i>copayment</i> per visit, then payable at 100%.	Subject to <i>deductible</i> and <i>coinsurance</i> .
<i>Urgent Care Facility, Ancillary and Qualified Practitioner Services</i>	Subject to a \$50 <i>copayment</i> per visit, then payable at 100%.	Subject to <i>deductible</i> and <i>coinsurance</i> .
<i>Qualified Practitioner (Office Visits)</i>	Subject to a \$15 <i>copayment</i> per visit, then payable at 100%.	Subject to <i>deductible</i> and <i>coinsurance</i> .
	If an office examination is billed from an outpatient location, the <i>services</i> will be payable the same as an office examination at a clinic.	
<i>Qualified Practitioner (Other than Office Visits)</i>	Subject to <i>deductible</i> and <i>coinsurance</i> .	Subject to <i>deductible</i> and <i>coinsurance</i> .
Injection, other than routine	Subject to a \$5 <i>copayment</i> per visit, then payable at 100%.	Subject to <i>deductible</i> and <i>coinsurance</i> .

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

Schedule of Benefits Continued

MEDICAL COVERED EXPENSES		
BENEFIT	PAR PROVIDER (IN-NETWORK)	NON-PAR PROVIDER* (OUT-OF-NETWORK)
<u>Diagnostic X-ray and Lab</u>		
Office setting (same site/same day as office visit)	Subject to a \$15 office visit <i>copayment</i> per visit, then payable at 100%.	Subject to <i>deductible</i> and <i>coinsurance</i> .
Independent Lab	Subject to <i>deductible</i> and <i>coinsurance</i> .	Subject to <i>deductible</i> and <i>coinsurance</i> .
<i>Outpatient X-ray</i>	Subject to <i>deductible</i> and <i>coinsurance</i> .	Subject to <i>deductible</i> and <i>coinsurance</i> .
<i>Inpatient</i> setting	Subject to <i>deductible</i> and <i>coinsurance</i> and <i>copayment</i> .	Subject to <i>deductible</i> and <i>coinsurance</i> .
<i>Emergency Room</i> setting	Subject to <i>deductible</i> and <i>emergency copayment</i> , then payable at 100%.	Subject to <i>deductible</i> and <i>coinsurance</i> .
<u>Advanced Imaging</u>		
Office setting (same site/same day as office visit)	Subject to a \$15 office visit <i>copayment</i> per visit, then payable at 100%.	Subject to <i>deductible</i> and <i>coinsurance</i> .
<i>Outpatient</i> setting	Subject to <i>deductible</i> and <i>coinsurance</i> .	Subject to <i>deductible</i> and <i>coinsurance</i> .
<u>Anesthesia and Surgery Services</u>		
Office or Clinic Setting	Subject to a \$15 office visit <i>copayment</i> per visit, then payable at 100%.	Subject to <i>deductible</i> and <i>coinsurance</i> .
<i>Inpatient</i> or <i>Outpatient</i> Setting	Subject to <i>deductible</i> and <i>coinsurance</i> .	Subject to <i>deductible</i> and <i>coinsurance</i> .
Second Surgical Opinion	Subject to a \$15 <i>copayment</i> per visit, then payable at 100%.	Subject to <i>deductible</i> and <i>coinsurance</i> .
Assisting the Surgeon	20% of the primary surgeon's fee, subject to <i>deductible</i> and <i>coinsurance</i> .	20% of the primary surgeon's fee, subject to <i>deductible</i> and <i>coinsurance</i> .

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

Schedule of Benefits Continued

MEDICAL COVERED EXPENSES		
BENEFIT	PAR PROVIDER (IN-NETWORK)	NON-PAR PROVIDER* (OUT-OF-NETWORK)
<i>Physician Assistant</i>	20% of the primary <i>physician's</i> fee, subject to <i>deductible</i> and <i>coinsurance</i> .	20% of the primary <i>physician's</i> fee, subject to <i>deductible</i> and <i>coinsurance</i> .
<u>Routine Child Care (Ages 0-18)</u>		
Exam	Subject to a \$15 <i>copayment</i> per visit, then payable at 100%.	Subject to <i>deductible</i> and <i>coinsurance</i> .
Immunizations	Payable at 100% after office visit <i>copayment</i> .	Subject to <i>deductible</i> and <i>coinsurance</i> .
Flu/Pneumonia, HPV and Meningitis Vaccines, Lab and X-ray (same site/same day as office visit)	Payable at 100%.	Subject to <i>deductible</i> and <i>coinsurance</i> .

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

MEDICAL COVERED EXPENSES		
BENEFIT	PAR PROVIDER (IN-NETWORK)	NON-PAR PROVIDER* (OUT-OF-NETWORK)
<u>Routine Adult Care (Ages 18 and over)</u>		
Exam,	Subject to a \$15 <i>copayment</i> per visit, then payable at 100%.	Subject to <i>deductible</i> and <i>coinsurance</i> .
Immunizations	Payable at 100% after office visit <i>copayment</i> .	Subject to <i>deductible</i> and <i>coinsurance</i> .
Flu/Pneumonia, HPV, Shingles and Meningitis Vaccines, Lab and X-ray, Prostate Antigen Testing, Routine Pap Smear, Immunizations, Routine Mammogram, Cardiovascular Screening Blood Test, Colonoscopy, Proctosigmoidoscopy and Sigmoidoscopy Screening Test, Bone Mass Measurements and Glaucoma Screening (same site/same day as office visit)	Payable at 100%.	Subject to <i>deductible</i> and <i>coinsurance</i> .
<p>Sometimes during the course of a screening procedure (routine wellness or preventive care), abnormalities or problems may be identified that require immediate intervention or additional diagnosis. If this occurs, and <i>your provider</i> performs additional necessary procedures, the <i>service</i> will be considered diagnostic and/or surgical, rather than screening, depending on the claim for the <i>services</i> submitted by <i>your provider</i>. This may result in a possible difference in <i>your copayment</i> and/or <i>coinsurance</i>.</p>		

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

Schedule of Benefits Continued

MEDICAL COVERED EXPENSES		
BENEFIT	PAR PROVIDER (IN-NETWORK)	NON-PAR PROVIDER* (OUT-OF-NETWORK)
<i>Ambulance Service</i>	Subject to <i>deductible</i> and <i>coinsurance</i> .	Subject to PAR <i>deductible</i> and PAR <i>coinsurance</i> per billed charges.
<u>Pregnancy Benefits</u>		
<i>Facility Services</i>	Subject to a \$100 <i>copayment</i> per admission, then <i>deductible</i> and payable at 100%.	Payable the same as any other <i>sickness</i> .
<i>Qualified Practitioner Services</i>	Payable the same as any other <i>sickness</i> .	Payable the same as any other <i>sickness</i> .
	Office visit <i>copayment</i> is limited to the office visit in which pregnancy is diagnosed. Thereafter, no <i>copayment</i> required.	
<u>Inpatient Newborn Benefits</u>		
<i>Facility Services</i>	Payable at 100%.	Subject to <i>coinsurance</i> .
<i>Qualified Practitioner Services</i>	Payable at 100%.	Subject to <i>deductible</i> and <i>coinsurance</i> .
	The newborn <i>deductible</i> and <i>copayment</i> will be waived for facility <i>services</i> .	
<i>Skilled Nursing Facility</i>	Subject to <i>deductible</i> and <i>coinsurance</i> .	Subject to <i>deductible</i> and <i>coinsurance</i> .
	PAR and Non-PAR <i>covered expenses</i> aggregate to a maximum of 30 days per <i>calendar year</i>	
<i>Home Health Care</i>	Subject to <i>deductible</i> and <i>coinsurance</i> .	Subject to <i>deductible</i> and <i>coinsurance</i> .
	PAR and Non-PAR <i>covered expenses</i> aggregate to a maximum of 60 visits per <i>calendar year</i> .	
<i>Hospice Care</i>	Same as <i>Medicare</i> benefit.	Same as <i>Medicare</i> benefit.
<u>Chiropractic Care</u>		
Exam, Therapy, and Manipulations	Subject to a \$15 <i>copayment</i> per visit, then payable at 100%.	Subject to <i>deductible</i> and <i>coinsurance</i> .
Lab and X-ray (same site/same day as office visit)	Payable at 100% after office visit <i>copayment</i> .	Subject to <i>deductible</i> and <i>coinsurance</i> .
	PAR and Non-PAR <i>covered expenses</i> aggregate to a maximum of 26 visits per <i>calendar year</i> , with no more than 1 visit per day.	

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

Schedule of Benefits Continued

MEDICAL COVERED EXPENSES		
BENEFIT	PAR PROVIDER (IN-NETWORK)	NON-PAR PROVIDER* (OUT-OF-NETWORK)
Physical Therapy	Subject to <i>deductible</i> and <i>coinsurance</i> .	Subject to <i>deductible</i> and <i>coinsurance</i> .
	PAR and Non-PAR <i>covered expenses</i> aggregate to a maximum of 30 visits.	
Occupational Therapy	Subject to <i>deductible</i> and <i>coinsurance</i> .	Subject to <i>deductible</i> and <i>coinsurance</i> .
	PAR and Non-PAR <i>covered expenses</i> aggregate to a maximum of 30 visits.	
Speech Therapy	Subject to <i>deductible</i> and <i>coinsurance</i> .	Subject to <i>deductible</i> and <i>coinsurance</i> .
	PAR and Non-PAR <i>covered expenses</i> aggregate to a maximum of 30 visits.	
Cognitive Therapy	Subject to <i>deductible</i> and <i>coinsurance</i> .	Subject to <i>deductible</i> and <i>coinsurance</i> .
	PAR and Non-PAR <i>covered expenses</i> aggregate to a maximum of 30 visits.	
Cardiac Rehabilitation Therapy (Phase I and II)	Subject to <i>deductible</i> and <i>coinsurance</i> .	Subject to <i>deductible</i> and <i>coinsurance</i> .
	PAR and Non-PAR <i>covered expenses</i> aggregate to a maximum of 30 visits.	
Respiratory Therapy	Subject to <i>deductible</i> and <i>coinsurance</i> .	Subject to <i>deductible</i> and <i>coinsurance</i> .
Chemotherapy and Radiation Therapy	Subject to <i>deductible</i> and <i>coinsurance</i> .	Subject to <i>deductible</i> and <i>coinsurance</i> .
<i>Rehabilitation Centers</i>	Subject to <i>deductible</i> and <i>coinsurance</i> .	Subject to <i>deductible</i> and <i>coinsurance</i> .
<u>Allergy Services</u>		
Allergy Testing	Subject to a \$15 office visit <i>copayment</i> per visit, then payable at 100%.	Subject to <i>deductible</i> and <i>coinsurance</i> .
Allergy Serum/Vials	Payable at 100%.	Subject to <i>deductible</i> and <i>coinsurance</i> .
Allergy Injections	Subject to a \$5 <i>copayment</i> per visit, then payable at 100%.	Subject to <i>deductible</i> and <i>coinsurance</i> .
	<i>Copayments</i> for allergy injections and office visits are applied per visit (highest <i>copayment</i> will apply).	

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

Schedule of Benefits Continued

MEDICAL COVERED EXPENSES		
BENEFIT	PAR PROVIDER (IN-NETWORK)	NON-PAR PROVIDER* (OUT-OF-NETWORK)
<i>Hearing Aids (Covered persons under 18 years of age)</i>	Subject to <i>deductible</i> and <i>coinsurance</i> .	Subject to <i>deductible</i> and <i>coinsurance</i> .
	PAR and Non-PAR <i>covered expenses</i> aggregate to a maximum of 1 <i>hearing aid</i> per ear every 3 years, up to a <i>maximum benefit</i> of \$1,400 per ear.	
Temporomandibular Joint Disorder	Payable the same as any other <i>sickness</i> .	Payable the same as any other <i>sickness</i> .
Audiometric (in conjunction with a disease, <i>sickness</i> or <i>injury</i>)	Payable the same as any other <i>sickness</i> .	Payable the same as any other <i>sickness</i> .
<i>Mental Disorder</i> , Chemical Dependence and Alcoholism	Payable the same as any other <i>sickness</i> .	Payable the same as any other <i>sickness</i> .
<u>Family Planning</u>		
Birth Control Devices, Contraceptive Injections and Contraceptive Implant Systems (Office or Clinic Setting)	Subject to a \$15 <i>copayment</i> , then payable at 100%.	Subject to <i>deductible</i> and <i>coinsurance</i> .
Birth Control Devices, Contraceptive Injections and Contraceptive Implant Systems (<i>Outpatient</i> Setting)	Subject to <i>deductible</i> and <i>coinsurance</i> .	Subject to <i>deductible</i> and <i>coinsurance</i> .
Dental Injury	Payable the same as any other <i>sickness</i> .	Payable the same as any other <i>sickness</i> .
<u>Lenses/Frames/Contacts following Cataract Surgery limited to one pair</u>		
Office or Clinic Setting	Subject to the office visit <i>copayment</i> per visit, then payable at 100%.	Subject to <i>deductible</i> and <i>coinsurance</i> .
<i>Inpatient</i> or <i>Outpatient</i> Setting	Subject to <i>deductible</i> and <i>coinsurance</i> .	Subject to <i>deductible</i> and <i>coinsurance</i> .
Other Covered Expenses	Subject to <i>deductible</i> and <i>coinsurance</i> .	Subject to <i>deductible</i> and <i>coinsurance</i> .

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

Schedule of Benefits Continued

MEDICAL COVERED EXPENSES		
BENEFIT	PAR PROVIDER (IN-NETWORK)	NON-PAR PROVIDER* (OUT-OF-NETWORK)
Sterilization	Payable the same as any other <i>sickness</i> .	Payable the same as any other <i>sickness</i> .
Medical/Surgical Supplies	Payable at 100%.	Subject to <i>deductible</i> and <i>coinsurance</i> .
Durable Medical Equipment	Subject to <i>deductible</i> and <i>coinsurance</i> .	Subject to <i>deductible</i> and <i>coinsurance</i> .
<u>Prosthesis</u>		
Office or Clinic Setting	Subject to a \$15 <i>copayment</i> per visit, then payable at 100%.	Subject to <i>deductible</i> and <i>coinsurance</i> .
<i>Inpatient</i> or <i>Outpatient</i> Setting	Subject to <i>deductible</i> and <i>coinsurance</i> .	Subject to <i>deductible</i> and <i>coinsurance</i> .
<i>Morbid Obesity</i> Surgical	Payable the same as any other <i>sickness</i> , subject to certain guidelines and must receive prior approval.	Payable the same as any other <i>sickness</i> , subject to certain guidelines and must receive prior approval.

MEDICAL COVERED EXPENSES		
BENEFIT	HUMANA NATIONAL TRANSPLANT NETWORK FACILITY (PAYABLE AT THE PAR BENEFIT LEVEL) (IN-NETWORK)	OTHER THAN A HUMANA NATIONAL TRANSPLANT NETWORK FACILITY (PAYABLE AT THE NON- PAR BENEFIT LEVEL)* (OUT-OF-NETWORK)
Organ Transplants	Payable the same as any other <i>sickness</i> .	Payable the same as any other <i>sickness</i> .
Lodging and Transportation Services	Subject to <i>deductible</i> and <i>coinsurance</i> . Limitations apply. See pages 37-40.	Subject to <i>deductible</i> and <i>coinsurance</i> . Limitations apply. See pages 37-40.
<i>Covered expenses</i> for organ transplants aggregate toward the out-of-pocket limits described in the Schedule of Benefits.		

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

UTILIZATION/CASE MANAGEMENT

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

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

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

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

PRECERTIFICATION

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

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

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

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

1. Advise *you* in writing if the proposed treatment plan is *medically necessary*;
2. Advise *you* in writing the number of days the *confinement* is initially *precertified*; and
3. Conduct *concurrent review* as necessary.

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

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

Utilization/Case Management Continued

PENALTY FOR NOT OBTAINING PRECERTIFICATION

If *your qualified practitioner* does not obtain *precertification* for *services* being rendered, *your* benefits for *hospital* or *qualified treatment facility* may be reduced.

SECOND SURGICAL OPINION

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

INFORMED CARE MANAGEMENT

The Informed Care Management Program is a *confidential service* to assist *you* in managing *your* or *your* covered dependent's health condition. The goal is to help *you* by having a *Personal Nurse* provide education and information to assist *you* in working with *your* practitioner. The nurse will work with *you* to identify warning signs and risks, as well as, work with *you* to establish health goals. *You* may be contacted by *ActiveHealth* Management to participate in this confidential program or *you* may call *ActiveHealth* to enroll at 877-597-7474.

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

Utilization/Case Management Continued

- **Cerebrovascular/Stroke; Hypertension; Peripheral Artery Disease; Chronic Obstructive Pulmonary Disease (COPD); Osteoporosis Primary and Secondary; Gastroesophageal Reflux Disease (GERD); Peptic Ulcer Disease; Inflammatory Bowel Disease (IBD)/Crohn's; Chronic Hepatitis; Geriatrics; Seizure Disorders; Migraine; Hypercoagulable State; Oncology; HIV Support; Low Back Pain:** These programs are designed to educate *you* and coordinate the multiple facets of *your* care.
- **Why Weight Kentucky:** This program is designed to assist *you* in achieving and maintaining a healthy weight. *Members* will be identified as potential candidates for the program through self-referral, Personal Health Analysis and claims data. In order to participate in this program *you* must have a BMI equal to or greater than 30.

PREDETERMINATION OF MEDICAL BENEFITS

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

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

MEDICAL DEDUCTIBLE AND COINSURANCE INFORMATION

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

DEDUCTIBLE

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

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

MAXIMUM FAMILY DEDUCTIBLE

The total *deductible* applied to all *covered persons* in one family in a *calendar year* is subject to the maximum shown on the Schedule of Benefits. No one individual is required to meet the total family *deductible*.

If *you* have more than one family member covered under *your plan*, one family member may satisfy the individual \$500 *deductible* and the remaining \$1,000 family *deductible* may be met by any combination of the remaining family member's claims up to the \$1,500 family *deductible* maximum. Here are the *deductible* rules:

- No single family member will pay more than \$500 in *deductible*;
- No single family member can contribute more than \$500 to the family *deductible* maximum; and,
- Of the \$1,500 family maximum *deductible*, \$500 can be met by a family member and the remaining \$1,000 can be met by a combination of additional family members or,
- All family members' services can be combined and applied to meet the family \$1,500 *deductible*.
- If only two family *members* are covered under this *Plan* (*employee* and spouse or *employee* and one child), each covered *member* will have a \$500 *deductible*. *You* will not have to satisfy the family *deductible*.

COINSURANCE

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

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

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

OUT-OF-POCKET LIMIT

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

Medical Deductible and Coinsurance Information Continued

If only two family *members* are covered under this *Plan* (*employee* and spouse or *employee* and one child), each covered *member* will satisfy the individual out-of-pocket limit. *You* will not have to satisfy the family *out-of-pocket limit*.

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

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

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

LIFETIME MAXIMUM

This *Plan* does not include a lifetime maximum.

MEDICAL COVERED EXPENSES

INPATIENT HOSPITAL

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

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

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

OUTPATIENT HOSPITAL

Outpatient hospital/ambulatory surgical center facility/other provider services

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

EMERGENCY CARE

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

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

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

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

FREE-STANDING SURGICAL FACILITY

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

URGENT CARE

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

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

MEDICAL CARE TO INPATIENTS

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

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

QUALIFIED PRACTITIONER

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

1. Office, home, *emergency room physician* or *inpatient hospital* visits;
2. Diagnostic Testing which includes: laboratory tests, x-rays and other radiology or imaging *services*; and ultrasound and approved machine testing *services* performed for the purpose of diagnosing a *sickness* or injury.
3. Professional *services* of a radiologist or pathologist for diagnostic x-ray examination or laboratory tests, including x-ray, radon, radium and radioactive isotope therapy;
4. Other covered medical *services* received from or at the direction of a *qualified practitioner*;
5. Administration of anesthesia. Coverage is provided for the *services* of a *physician* or other professional *provider* (other than the surgeon or assistant surgeon) for administration of anesthesia, as ordered by the attending *physician*;
6. A surgical procedure, including pre-operative and post-operative care.

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

- a. 50% of the *maximum allowable fee* for the secondary procedure; and
- b. 25% of the *maximum allowable fee* for the third and subsequent procedures.

No benefits will be payable for incidental procedures.

7. Assisting the surgeon, payable at 20% of the *maximum allowable fee* allowed for the primary surgeon;

Qualified Practitioner Continued

8. *Physician* assistant, payable at 20% of the *maximum allowable fee* allowed for the primary surgeon;
9. Charges made by a *qualified practitioner* for *services* in performing certain oral surgical operations due to *bodily injury* or *sickness* are covered as follows:
 - a. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological examination;
 - b. Surgical procedures required to correct *accidental injuries* of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
 - c. Reduction of fractures and dislocations of the jaw; and
 - d. Incision of accessory sinuses, salivary glands or ducts.

ROUTINE CARE

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

Benefits include:

1. Routine Physical and Well Woman exams, one each per *calendar year*;
2. Immunizations, in accordance with recommendations of the Advisory Council on Immunization Practices of the Centers for Disease Control and Prevention and Therapeutic injections;
3. Pap smears;
4. Mammograms;
5. Routine x-ray and laboratory tests;
6. Prostate antigen testing;
7. Cardiovascular Screening Blood Test;
8. Colonoscopy, Proctosigmoidoscopy and Sigmoidoscopy Screening Tests;

Routine Care Continued

9. Bone Mass Measurements;
10. Glaucoma Screening;
11. Flu/Pneumonia Injections;
12. HPV Vaccine (i.e. Gardasil), covered females ages 9 through 26;
13. Meningitis Vaccine, *covered persons* through age 21;
14. Shingles Vaccine (i.e. Zostavax), *covered persons* age 60 and over.

No benefits are payable under this benefit for:

1. Any dental examinations;
2. Hearing examinations;
3. Medical examination for *bodily injury* or *sickness*;
4. Medical examination caused by or resulting from pregnancy.

AMBULANCE SERVICE

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

Air *ambulance services* are covered when *medically necessary* and the attending physician, or the Plan determines an air *ambulance* is the only medically appropriate means of transportation to the nearest appropriate facility.

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

PREGNANCY BENEFITS

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

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

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

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

MATERNITY PROGRAM

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

The maternity program offers *you*:

- A Personalized Care plan
- A Nurse Care Manager to support and educate *you* during *your* pregnancy
- A Nurse Care Manager to help to prepare questions to discuss with *your* doctor

To join, call KYSPIRIT: 1-877-597-7474

NEWBORN BENEFITS

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

WELL-NEWBORN

Covered expenses incurred during a well-newborn child's initial *inpatient hospital confinement* include *hospital* expenses for nursery room and board and miscellaneous *services*; *qualified practitioner's* expenses for circumcision; and *qualified practitioner's* expenses for routine examination before release from the *hospital*. The deductible is waived for the first 30 days of life, regardless of whether it is a facility or physician charge.

SICK-NEWBORN

Covered expenses for a sick-newborn are *expenses incurred* for the treatment of a *bodily injury* or *sickness*. The deductible is waived for the first 30 days of life, regardless of whether it is a facility or physician charge.

SKILLED NURSING FACILITY

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

1. Begins while *you* or an eligible *dependent* are covered under this *Plan*;
2. Begins after discharge from a *hospital confinement* or a prior covered skilled nursing facility *confinement*;
3. Is necessary for care or treatment of the same *bodily injury* or *sickness* which caused the prior *confinement*; and
4. Occurs while *you* or an eligible *dependent* are under the regular care of the *physician* who *precertified* the required skilled nursing facility *confinement*.

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

1. Permanent and full-time bed care facilities for resident patients;
2. A *physician's services* available at all times;
3. 24-hour-a-day skilled nursing *services* under the full-time supervision of a *physician* or registered nurse (R.N.);
4. A daily record for each patient;
5. Continuous *skilled nursing care* for sick or injured persons during their convalescence from *sickness* or *bodily injury*; and
6. A *utilization review* plan.

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

BENEFITS PAYABLE FOR SKILLED NURSING

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

HOME HEALTH CARE

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

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

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

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

1. Hospitalization or *confinement* in a skilled nursing facility would otherwise be required if home care were not provided;
2. Necessary care and treatment are not available from a *family member* or other persons residing with *you*; and
3. The home health care *services* will be provided or coordinated by a state-licensed or *Medicare*-certified *home health agency* or certified rehabilitation agency.

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

The home health care plan consists of:

1. Care by or under the supervision of a registered nurse (R.N.);
2. Physical, speech, occupational and respiratory therapy and home health aide *services*; and
3. Medical supplies and *durable medical equipment*, laboratory *services* and nutritional counseling, if such *services* and supplies would have been covered if *you* were *hospital* confined.

LIMITATIONS ON HOME HEALTH CARE BENEFITS

Home health care benefits do not include:

1. Charges for mileage or travel time to and from the *covered person's* home;
2. Wage or shift differentials for home health care *providers*; or
3. Charges for supervision of home health care *providers*.

HOSPICE CARE

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

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

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

1. Room and board and other *services* and supplies;
2. Part-time nursing care by or supervised by a R.N. for up to 8 hours per day;
3. Counseling *services* by a *qualified practitioner* for the *hospice* patient and the immediate family;
4. Medical social *services* provided to *you* or *your* immediate family under the direction of a *qualified practitioner*, which include the following:
 - a. Assessment of social, emotional and medical needs, and the home and family situation,
 - b. Identification of the community resources available, and
 - c. Assistance in obtaining those resources;
5. Nutritional counseling;
6. Physical or occupational therapy;
7. Part-time home health aide service for up to 8 hours in any one day;
8. Medical supplies, drugs and medicines prescribed by a *qualified practitioner*; and
9. Bereavement counseling *services* by a *qualified practitioner* for *your* immediate family.

LIMITATIONS ON HOSPICE CARE BENEFITS

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

Hospice Care Continued

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

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

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

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

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

CHIROPRACTIC CARE

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

HEARING AIDS AND RELATED SERVICES

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

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

TEMPOROMANDIBULAR JOINT DISORDER

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

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

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

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

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

MENTAL DISORDER, CHEMICAL DEPENDENCE OR ALCOHOLISM BENEFIT

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

1. Charges made by a *qualified practitioner*;
2. Charges made by a *hospital*;
3. Charges made by a *qualified treatment facility*;
4. Charges for x-ray and laboratory expenses.

Mental Disorder, Chemical Dependence or Alcoholism Benefit Continued

INPATIENT BENEFITS

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

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

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

OUTPATIENT BENEFITS

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

PAR PROVIDER (IN-NETWORK)	NON-PAR PROVIDER (OUT-OF-NETWORK)
Subject to a \$15 <i>copayment</i> , then payable at 100%.	Subject to <i>deductible</i> and payable at 60%.

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

PARTIAL HOSPITALIZATION

Covered expenses received for *partial hospitalization* arrangements are payable as shown below:

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

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

AUTISM BENEFITS

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

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

Mental Disorder, Chemical Dependence or Alcoholism Benefit Continued

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

AUTISM BENEFIT	PAR PROVIDER (IN-NETWORK)	NON-PAR PROVIDER (OUT-OF-NETWORK)
Rehabilitative and Therapeutic Care <i>Services</i>	Subject to <i>deductible</i> and payable at 80%.	Subject to <i>deductible</i> and payable at 60%.
<i>Respite Care</i>	Subject to <i>deductible</i> and payable at 80%.	Subject to PAR <i>deductible</i> and payable at 80%.

LIMITATIONS ON MENTAL DISORDER, CHEMICAL DEPENDENCE OR ALCOHOLISM BENEFITS

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

No benefits are payable under this provision for *services* performed at a Residential Treatment Facility or Half-way House.

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

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

KENTUCKY EMPLOYEE ASSISTANCE PROGRAM (KEAP) FOR STATE AGENCIES

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

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

OTHER COVERED EXPENSES

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

1. Blood and blood plasma are payable as long as it is NOT replaced by donation, and administration of blood and blood products including blood extracts or derivatives;
2. Oxygen and rental of equipment for its administration;
3. Initial prosthetic devices or supplies, including but not limited to, limbs and eyes, are covered. Coverage will be provided for covered prosthetic devices or supplies necessary to restore minimal basic function. Replacement for covered prosthetic devices or supplies are a *covered expense* if due to pathological changes. *Covered expense* includes repair of covered prosthetic device if by the manufacturer does not cover the repair. Coverage for penile prosthetics/implants are excluded for coverage unless related to penile trauma or amputation, and unless related to reconstructive *services* related to penile trauma or amputation;
4. Casts, trusses, crutches, *orthotics*, splints and braces. *Orthotics* must be custom made or custom fitted, made of rigid or semi-rigid material. Fabric supports, replacement *orthotics* and braces, oral splints and appliances and dental splints and dental braces are not a *covered expense*;
5. Covered supplies, up to a 30-day supply, when prescribed by *your* attending *physician*;
6. Initial contact lenses or eyeglasses following cataract *surgery*;
7. The rental, up to but not to exceed the purchase price, of a wheelchair, *hospital* bed, ventilator, *hospital* type equipment or other *durable medical equipment (DME)*. The Plan, at its option, may authorize the purchase of *DME* in lieu of its rental, if the rental price is projected to exceed the purchase price. Replacement for covered *DME* is a *covered expense* if due to pathological changes. Repair, maintenance or duplicate *DME* rental is not considered a *covered expense*;
8. Chiropractic care for treatment of a *bodily injury* or *sickness*, limitations apply, see Schedule of Benefits. *Maintenance care* is not covered;
9. *Services* for the treatment of a *dental injury* to a *sound natural tooth*, including but not limited to extraction and initial replacement. The *dental injury* shall be of sufficient significance that initial contact for evaluation shall occur within 72 hours of the accident. *Services* must begin within 90 days and be completed within 12 months after the date of the *dental injury*. Benefits will be paid only for *expense incurred* for the least expensive *service* that will, in the *Plan Manager's* opinion, produce a professionally adequate result;

Other Covered Expenses Continued

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

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

11. Installation and use of an insulin infusion pump, diabetic self-management education programs and other equipment in the treatment of diabetes;
12. Reconstructive *surgery* due to *bodily injury*, infection or other disease of the involved part or congenital disease or anomaly of a covered *dependent* child which resulted in a functional defect;
13. Reconstructive *services* following a covered mastectomy, including but not limited to:
 - a. reconstruction of the breast on which the mastectomy was performed;
 - b. reconstruction of the other breast to achieve symmetry;
 - c. prosthesis; and
 - d. treatment of physical complications of all stages of the mastectomy, including lymphedemas;
14. Speech, occupational, cognitive, and physical therapy, limitations apply, see Schedule of Benefits;
15. Chemotherapy, radiation and respiratory therapy, as *medically necessary*;
16. Cardiac rehabilitation, limited to phases I and II, limitations apply, see Schedule of Benefits;
17. Surgery for *morbid obesity*, when qualified as *morbid obesity*, *medically necessary* and the *covered persons* condition is of a life-threatening nature, limitations apply, including but not limited to:
 - a. six month doctor supervised diet; and
 - b. BMI of 40 or more;
18. Audiometric *services* covered only in conjunction with a disease, *sickness* or injury;
19. Cochlear Implants;

Other Covered Expenses Continued

20. *Telehealth* Consultation *services*. Covered *services* include a medical or health consultation for purposes of patient diagnosis or treatment that requires the use of advanced telecommunications technology, including, but not limited to: (a) compressed digital interactive video, audio, or data transmission; and (b) clinical data transmission via computer imaging for teleradiology or telepathology; and (c) other technology that facilitates access to other covered health care *services* or medical specialty expertise;
21. Bone Density Testing for women ages 35 and older;
22. Immunizations in accordance with recommendations of the Advisory Council on Immunization Practices of the Centers for Disease Control and Prevention and Therapeutic injections;
23. Therapy and testing for treatment of allergies, including but not limited to, skin titration (Rinkel Test), cytotoxicity testing (Bryan's Test), urine auto injection, provocative and neutralization testing for allergies, or for an assessment of IgG antibodies in food allergies, *services* related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts, neutralization test and/or treatment UNLESS such therapy or testing is NOT approved by:
 - a. The American Academy of Allergy and Immunology, or
 - b. The Department of Health and Human Services or any of its offices or agencies;

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

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

ORGAN TRANSPLANT BENEFIT

Precertification is required. If *precertification* is not received, organ transplant *services* will not be covered.

The Plan will pay benefits for the expense of a transplant as defined below for a *covered person* when approved in advance by the *Plan Manager*, subject to those terms, conditions and limitations described below and contained in the Plan. Please contact the *Plan Manager* at our toll free number (866) 421-5663 when in need of these *services*.

Organ Transplant Benefit Continued

COVERED ORGAN TRANSPLANT

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

1. Heart;
2. Lung(s);
3. Liver;
4. Kidney;
5. Bone Marrow;*
6. Intestine;
7. Pancreas;
8. Auto islet cell;
9. Multivisceral;
10. Any combination of the above listed organs;
11. Any organ not listed above required by state or federal law.

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

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

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

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

Organ Transplant Benefit Continued

ORGAN TRANSPLANT EXCLUSIONS

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

1. It is *experimental, investigational or for research purposes* as defined in the Definitions section of this booklet.
2. The *Plan Manager* is not contacted for authorization prior to referral for evaluation of the transplant, unless such authorization is waived by the *Plan Manager*.
3. The *Plan Manager* does not approve coverage for the transplant, based on its established criteria.
4. Expenses are eligible to be paid under any private or public research fund, government program except Medicaid, or another funding program, whether or not such funding was applied for or received.
5. The expense relates to the transplantation of any non-human organ or tissue, unless otherwise stated in the Plan.
6. The expense relates to the donation or acquisition of an organ for a recipient who is not covered by the Plan.
7. A denied transplant is performed; this includes the pre-transplant evaluation, pre-transplant *services*, the transplant procedure, post-discharge *services*, immunosuppressive drugs, and complications of such transplant.
8. The *covered person* for whom a transplant is requested has not met pre-transplant criteria as established by the *Plan Manager*.

COVERED ORGAN TRANSPLANT SERVICES

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

1. *Hospital* and *qualified practitioner* benefits, payable as shown on the Schedule of Benefits. If *services* are rendered at a Humana National Transplant Network (NTN) facility, *covered expenses* are paid in accordance to the NTN contracted rates.
2. Organ acquisition and donor costs. Except for bone marrow transplants, donor costs are not payable under the Plan if they are payable in whole or in part by any other group plan, insurance company, organization or person other than the donor's family or estate. Coverage for bone marrow transplants procedures will include costs associated with the donor-patient to the same extent and limitations associated with the *covered person*, except the reasonable costs of searching for the donor may be limited to the immediate *family members* and the National Bone Marrow Donor Program.

Organ Transplant Benefit Continued

3. Direct, non-medical costs for the *covered person* receiving the transplant will be paid for: (a) transportation to and from the *hospital* where the transplant is performed; and (b) temporary lodging at a prearranged location when requested by the *hospital* and approved by the *Plan Manager*. Transportation costs for the *covered person* to and from the *hospital* where the transplant is performed will be payable as shown on the Schedule of Benefits. These direct, non-medical costs are only available if the *covered person* lives more than 100 miles from the transplant facility.*
4. Direct, non-medical costs for one *member* of the *covered person's* immediate family or a companion (two *members* if the patient is under age 18 years) will be paid for: (a) transportation to and from the approved facility where the transplant is performed; and, (b) temporary lodging at a prearranged location during the *covered person's* confinement in a *hospital*. Transportation costs for the *covered person's* immediate *family member(s)* or companion(s) to and from the *hospital* where the transplant is performed will be payable as shown on the Schedule of Benefits. These direct, non-medical costs are only available if the *covered person's* immediate *family member(s)* or companion(s) live more than 100 miles from the transplant facility.*

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

LIMITATIONS AND EXCLUSIONS

The Plan does not provide benefits for:

1. *Services*:
 - a. Not furnished by a *qualified practitioner* or *qualified treatment facility*;
 - b. Not authorized or prescribed by a *qualified practitioner*;
 - c. Not covered by this Plan whether or not prescribed by a *qualified practitioner*;
 - d. Which are not provided;
 - e. For which no charge is made, or for which *you* would not be required to pay if *you* were not covered under this Plan unless charges are received from and reimbursable to the United States Government or any of its agencies as required by law; or
 - f. Furnished by or payable under any plan or law through any government or any political subdivision (this does not include *Medicare* or *Medicaid*);
 - g. Furnished for a military service connected *sickness* or *bodily injury* by or under an agreement with a department or agency of the United States Government, including the Department of Veterans Affairs;
 - h. Performed in association with a *service* that is not covered under this Plan;
 - i. Performed as a result of a complication arising from a *service* that is not covered under this Plan;
2. Routine eye exams, *services* to correct eye refractive disorders, eyeglass frames and lenses or contact lenses, the fitting or repair of eyeglass frames and lenses or contact lenses, unless specifically covered under this Plan;
3. Routine hearing exams, tests or screenings, other than the screening of a newborn in the hospital, *hearing aids*, the fitting or repair of *hearing aids*, unless specifically covered under this Plan. Audiograms and audiometric *services*, unless related to the diagnosis or management of a specific illness or traumatic injury, if otherwise covered.
4. Physical exams/immunizations except as otherwise provided, *services*, supplies, or other care for routine or periodic physical examinations, immunizations, or tests for screening purposes required by third parties, such as for employment, licensing, travel, school (except approved well visits), insurance, marriage, adoption, participation in athletics, or *services* conducted for medical research or examinations required by a court;
5. Elective abortions, unless the pregnancy is a life-threatening physical condition of the covered female person;

Limitations and Exclusions Continued

6. *Services* related to gender change;
7. *Services* for a reversal of sterilization;
8. *Services*, supplies, or other care for *cosmetic surgery*, and/or complications arising directly from the *cosmetic services*. *Cosmetic services* means *services* and surgical procedures performed to improve a *covered person's* appearance or to correct a deformity without restoring physical bodily function, unless *medically necessary*. The presence of a psychological condition does not make a cosmetic service *medically necessary* and will not entitle a *covered person* to coverage for *cosmetic services*. Examples of exclusions include, but are not limited to, removal of tattoos, scars, wrinkles or excess skin; *plastic surgery*; silicone injections or implants; electrolysis; wigs, including those used as cranial prosthesis; treatment of male pattern baldness; revision of previous elective procedures; keloids; pharmaceutical regimes; nutritional procedures or treatments; rhinoplasty; epikeratophakia *surgery*; skin abrasions which are performed as a treatment for acne; hair removal via laser therapy or any other method;
9. Dental *services* except as otherwise specifically provided, *services*, supplies, or other care for dental *services* and procedures involving tooth structures, extractions, gingival tissues, alveolar processes, dental x-rays (other than for an accidental injury), procedures of dental origin, odontogenic cysts/tumors, or any orthodontic, or periodontic treatment regardless of medical necessity, except that hospital *services* may be covered provided such *services* are pre-certified as *medically necessary* to safeguard the health of the covered person from the effects or side effects of a dental procedure due to a specific non-dental organic impairment. *Services* and supplies for maxillary and/or mandibular augmentation/implant procedures to facilitate the use of full or partial dental prosthesis, fixed or removable;
10. Any loss caused by or contributed to:
 - a. War or any act of war, whether declared or not, or
 - b. Any act of armed conflict, or any conflict involving armed forces of any authority;
11. Any drug, medicine or device which does not have the United States Food and Drug Administration formal market approval through a New Drug Application, Premarket Approval, 510K, or PLA;
12. Any *service* which is *experimental, investigational or for research purposes*;
13. *Pre-existing conditions* to the extent specified in the Definitions section;
14. *Custodial care* services, supplies, or other care rendered by or in: (a) rest homes; (b) health resorts; (c) homes for the aged; (d) places primarily for domiciliary or custodial care; and (e) self-help training or other forms of non-medical self-care;
15. *Services* provided by a person who ordinarily resides in *your* home or who is a *family member*;
16. Charges in excess of the *maximum allowable fee* for the *service*;

Limitations and Exclusions Continued

17. Any *expense incurred* prior to *your effective date* under the Plan or after the date *your* coverage under the Plan terminates, except as specifically described in this Plan;
18. *Services*, supplies, or other care provided in treatment of injuries sustained or illnesses resulting from participation in a riot or civil disturbance or while committing or attempting to commit an assault or felony. *Services*, supplies or other care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs;
19. *Services* not *medically necessary* for diagnosis and treatment of a *bodily injury* or *sickness*;
20. Private duty nursing;
21. *Expenses incurred* for which *you* are entitled to receive benefits under *your* previous dental or medical plan;
22. All fertility testing or *services* (other than diagnostic testing or *services*), including any artificial means to achieve pregnancy or ovulation, such as artificial insemination, in vitro fertilization, spermatogenesis, gamete intra fallopian transfer (GIFT), zygote intra fallopian transfer (ZIFT), tubal ovum transfer, embryo freezing or transfer and sperm banking;
23. Professional pathology or radiology charges, including but not limited to, blood counts, multi-channel testing, and other clinical chemistry tests, when:
 - a. The *services* do not require a professional interpretation, or
 - b. The *qualified practitioner* did not provide a specific professional interpretation of the test results of the *covered person*;
24. *Prescription* drugs, except as provided through the Pharmacy Benefit Manager's Summary Plan Description;
25. Penile implants and prosthetics, or any other *services* for the diagnosis or treatment of sexual dysfunction/impotence are not covered unless related to penile trauma or amputation, or unless related to reconstructive *services* related to penile trauma or amputation;
26. *Services* for the treatment of obesity, unless specifically indicated in Other Covered Expenses section. Any *surgery* for the removal of excess fat or skin following weight loss due to obesity, *surgery*, or pregnancy or services at a health spa or similar facility. *Services*, supplies, or other care for gastric bubble/gastric balloon procedures, stomach stapling, wiring of the jaw, liposuction and jejunal bypasses. Dietary supplements, diet pills and appetite suppressants;
27. No benefits are payable under this provision for residential treatment *services* or any *services* performed at a Residential Treatment Facility;

Limitations and Exclusions Continued

28. Vision therapy;
29. Smoking cessation products, except as covered and provided through the Pharmacy Benefit Manager;
30. Birth control pills, except as covered and provided through the Pharmacy Benefit Manager's Summary Plan Description;
31. Removal of the implants and implant systems, except when *medically necessary*;
32. *Services*, supplies and other care for acupuncture, anesthesia by hypnosis, or anesthesia charges for *services* not covered by this plan;
33. *Services*, supplies, or other care provided for conditions related to conduct disorders (except attention deficit disorders), pervasive developmental disorders (except *autism*), behavioral disorders, learning disabilities and disorders, or mental retardation. *Services*, supplies or other care for non-chemical addictions such as gambling, sexual, spending, shopping and working addictions, codependency, or caffeine addition. Milieu therapy, marriage counseling, *inpatient* admissions for environmental change, biofeedback, neuromuscular re-education, hypnotherapy, sleep therapy, vocational rehabilitation, sensory integration, educational therapy and recreational therapy, except for such adjunct *services* as part of the *inpatient* stay and required by the Joint Commission on Accreditation of Healthcare Organizations or the Commission of Accreditation of Rehabilitative Facilities;
34. Disposable supplies, normally purchased in an over the counter setting, to an *outpatient* facility including, but not limited to, ace bandages, support hosiery, pressure garments, elastic stockings, and band-aids;
35. Modifications to *your* home or place of business, such as ramps, air conditioners, seat lift chairs or supplies or attachments for any of these items; professional medical equipment such as blood pressure kits; purchase or rental of escalators or elevators; spas, saunas or swimming pools. Any *durable medical equipment*, prosthesis, or orthotic device having convenience or luxury features which are not *medically necessary*, except that benefits for the cost of standard equipment or device used in the treatment of disease, illness, or injury will be provided toward the cost of any deluxe equipment, prosthetic or device selected. Benefits are excluded for the repair, maintenance and/or replacement of *durable medical equipment*, except as otherwise provided. Vehicle adjustments, air purifiers, free-standing humidifiers, dehumidifiers, stair-gliders, *Emergency Alert* equipment, handrails, heat appliances, waterbeds, whirlpool baths, exercise and massage equipment;
36. *Services* or supplies for routine foot care or other care used in treatment of superficial lesions of the feet such as corns, hyperkeratosis, bunions, tarsalgia, metatarsalgia (except capsular or bone surgery), callouses, nails of the feet (except mycotic infections or surgery for ingrown nails), flat feet, fallen arches, weak feet, or similar conditions, unless *medically necessary* for complications of diabetes;

Limitations and Exclusions Continued

37. *Services*, supplies or other care for personal hygiene, environmental control, convenience items (including, but not limited to, air conditioners, humidifiers, or physical fitness equipment), or personal comfort and convenience items (such as daily television rental, telephone services, cots or visitors' meals). Charges for:
 - a. Telephone consultations;
 - b. Failure to keep a scheduled visit;
 - c. Completion of a *claim* form; or
 - d. Providing requested information to the *Plan*.
38. *Services* or supplies provided for self-help training or other form of non-medical self-care. Purchase or rental of supplies of common household use such as exercise cycles, air purifiers, central or unit air conditioners, water purifiers, allergenic pillows or mattresses or waterbeds, treadmill or special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program. *Services* or supplies at a health spa or similar Facility;
39. Food, food supplements (except special formulas *medically necessary* for the treatment of certain inborn errors of metabolism including PKU), minerals, vitamins, or drugs which could be purchased without a written prescription, or are not FDA approved for treatment of a specified category of medical conditions, or are not *medically necessary*, or are considered to be *experimental* or *investigational*, except as provided through the Pharmacy Benefit Manager's Summary Plan Description;
40. *Services*, supplies, or other care to the extent that benefits or reimbursement are available from or provided by any other group coverage, except that the *Plan* will coordinate the payment of benefits under this plan with such other coverage, as permitted by Kentucky Law;
41. Chelation therapy except in the treatment of lead or other heavy metal poisoning;
42. *Services*, supplies, or other care for educational or training procedures used in connection with speech except as otherwise defined in the Covered Services Section (Therapy Services), hearing, or vision *services*;
43. *Services*, supplies, or other care provided to an inpatient solely for cardiac rehabilitation. *Services*, supplies, or other care provided for non-human, artificial, or mechanical hearts or ventricular and/or atrial assist devices used as a heart replacement (when not otherwise provided in conjunction with a human organ transplant) and supportive *services* or devices in connection with such care. This exclusion includes *services* for implantation, removal, and complications;
44. Food, housing, home delivered meals, and homemaker services (such as housekeeping, laundry, shopping and errands). Teaching household routine to members of the *covered person's* family; supervision of a *covered person's* children; and other similar functions. Benefits are not provided for home health care education beyond the normal and customary period for learning. Supportive environmental materials, including hand rails, ramps, telephones, air conditioners and similar items. *Services* or supplies provided by the family of the *covered person* or volunteer ambulance associations. Visiting teachers, friendly visitors, vocational guidance, and other counselors. *Services* related to diversional and social activities. *Services* for which there is no cost to the *covered person*;

Limitations and Exclusions Continued

45. *Hospice services*, supplies, or other care except as covered by *Medicare's hospice* benefit;
46. Inpatient Diagnostic/Therapy – Non-emergency diagnostic admissions for inpatients or admissions primarily for therapy *services*, unless pre-authorized by the *Plan*;
47. *Services*, supplies, and other care related to suction-assisted lipectomy or diastasis recti repair, including instances when diastasis recti is associated with an umbilical or ventral hernia;
48. *Services*, supplies, or other care to the extent that Medicare is the primary payer. The *Plan* will coordinate the payment of benefits under this *plan* with Medicare, as permitted by Kentucky and Federal law;
49. *Services* or supplies for *mental health conditions* unless performed by a *physician* or other *provider* who is licensed or certified by the Commonwealth of Kentucky (or a corresponding licensing or certifying authority when the service is provided outside of the Commonwealth). *Services* for *mental health conditions* when provided for purposes of medical, educational, or occupational training. Psychological testing beyond that necessary to establish a diagnosis or beyond that approved by the subcontractor;
50. *Services*, supplies, or other care not meeting a *Plan's plan delivery system rules*.
51. Drugs that can be purchased without a written prescription. Amino acid modified preparations and low-protein modified food products for the treatment of lactose intolerance, protein intolerance, food allergy, food insensitivity, except as provided through the Pharmacy Benefit Manager's Summary Plan Description;
52. Travel or transportation expenses (except *ambulance*), even though prescribed by a physician. Air ambulance is excluded, unless emergency medical *services*, the attending physician, or the Plan determines an air *ambulance* is the only medically appropriate means of transportation to the nearest appropriate facility;
53. Work-related health conditions if the *covered person* is eligible for workers' compensation insurance and the condition is determined to be work-related and benefits are payable under workers' compensation insurance.

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

OPEN ENROLLMENT

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

EMPLOYEE ELIGIBILITY

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

1. *You* are an *employee* or *retiree* who meets the eligibility requirements of the *employer*; and
2. *You* participate in a state-sponsored retirement system; or
3. *You* are a School Board Member as defined in KRS 18A.225.

Your eligibility date is as determined by the Plan Sponsor.

EMPLOYEE EFFECTIVE DATE OF COVERAGE

You must enroll on forms acceptable to the Plan Sponsor.

1. If *your* completed enrollment forms are signed by *you* within 30 days after *your* hire date, *your* coverage is effective on the 1st day of the 2nd month following the month of hire. *Your* coverage may be effective at a later date as determined by the Plan Sponsor.
2. If *your* completed enrollment forms are signed by *you* more than 30 days after *your* hire date, *you* are a *late applicant* and *you* will not be eligible for coverage under this Plan until the next annual open enrollment period or until *you* experience a permitted *qualifying event*. *Your* coverage is effective as determined by the Plan Sponsor.

Eligibility and Effective Date of Coverage Continued

DEPENDENT ELIGIBILITY

Dependent eligibility requirements are outlined in the Definitions section of this document.

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

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

Each *dependent* is eligible for coverage on:

1. The date the *employee* is eligible for coverage, if he or she has *dependents* who may be covered on that date; or
2. The date of birth of the *employee's* natural-born child; or
3. The date a child is placed for adoption under the *employee's* legal guardianship, or the date which the *employee* incurs a legal obligation for total or partial support in anticipation of adoption; or
4. The date a covered *employee's* child is determined to be eligible as an alternate recipient under the terms of a medical child support order.

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

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

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

DEPENDENT EFFECTIVE DATE OF COVERAGE

If the *employee* wishes to add to the *Plan* a newborn *dependent*, a newly adopted *dependent*, or a newly placed for adoption *dependent*, an enrollment form must be completed and submitted to the Plan Sponsor.

The newborn *dependent's*, the newly adopted *dependent's*, or the newly placed for adoption *dependent's* effective date of coverage is determined as follows:

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

Eligibility and Effective Date of Coverage Continued

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

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

If the *employee* wishes to add to the *Plan* other *dependent(s)*, in addition to the newborn, the newly adopted *dependent*, or the newly placed for adoption *dependent*, an enrollment form must be completed and submitted to the Plan Sponsor.

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

1. If the completed enrollment forms are signed by *you* within 35 days after the newborn *dependent's*, the newly adopted *dependent's*, or the newly placed for adoption *dependent's* eligibility date, that newborn *dependent* and other *dependents* are covered on the date he or she is eligible.
2. If the completed enrollment forms are signed by *you* more than 35 days after the newborn *dependent's* eligibility date, the newborn *dependent* and other *dependents* are a *late applicant*. The newborn *dependent* and other *dependent* will not be eligible for coverage under this Plan until the next annual open enrollment period.

If the *employee* wishes to add other *dependent(s)* to the Plan, due to experiencing a *qualifying event* (other than birth, adoption, or placement for adoption), the *dependent's effective date* of coverage is determined as follows:

1. If the completed enrollment forms are signed by *you* within 35 days after the *qualifying event* that *dependent* is covered on the coverage effective date as set forth in the *qualifying events* in Exhibit A at the end of this document.
2. If the completed enrollment forms are signed by *you* more than 35 days after the *dependent's* eligibility date, the *dependent* is a *late applicant*. The *dependent* will not be eligible for coverage under this Plan until the next annual open enrollment period. The *dependent* is covered as determined by the *employer*.

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

Eligibility and Effective Date of Coverage Continued

FAMILY CROSS-REFERENCE PAYMENT OPTION

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

- *you* must cover at least one *dependent*;
- the *members* must be legally married (husband and wife);
- the *members* must be eligible *employees* or *retirees** of a group participating in the *Kentucky Employees Health Plan*;
- the *members* must elect the same coverage; and
- both *members* must sign the appropriate documentation during the enrollment process and file with their agency's Insurance Coordinators. If during open enrollment *you* enroll online, *you* will be required to enter both *members*' login credentials (user ID or personal ID number) via the web.

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

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

TERMINATING THE FAMILY CROSS-REFERENCE PAYMENT OPTION

Employees will not be eligible to continue the cross-reference payment option if one spouse loses eligibility (i.e. terminates employment, becomes part-time, or goes on leave without pay).

1. A Family Cross-Reference payment option is a legislatively mandated payment option for two (2) eligible *employees* or *retirees*. Thus, the Family Cross-Reference payment option has two (2) planholders.

If either planholder loses employment for any reason (voluntary or involuntary), the Family Cross-Reference payment option terminates as eligibility to participate in the Family Cross-Reference payment option has ceased. Only eligible *employees* may be planholders under the KEHP. Additionally, upon loss of employment that former planholder has lost planholder eligibility status and can only be covered as a *dependent* on that existing plan. As a result, the remaining planholder will be changed to parent-plus coverage (from Family Cross-Referencing) reflecting the loss of planholder status of the former planholder. Should the remaining planholder wish to elect *dependent* coverage for that former planholder, he or she may make that election for *dependent* coverage within 35 days of the date of loss of coverage of the former planholder.

The remaining planholder will **NOT** be responsible for the full regular family contribution unless that former planholder is added back to the plan as a *dependent*, which creates a traditional family plan.

2. A Family Cross-Reference payment option requires that the two (2) eligible *employees* be legally married to participate and receive the financial benefit. A divorce automatically terminates eligibility to participate in the Family Cross-Reference payment option. Each planholder has an affirmative obligation to notify the Department of Employee Insurance that eligibility to participate has ceased. A failure to notify the Department of Employee Insurance will result in penalties ranging from responsibility for premium arrearages to charges of insurance fraud.

Eligibility and Effective Date of Coverage Continued

MEDICAL CHILD SUPPORT ORDERS

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

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

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

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

PRE-EXISTING CONDITION LIMITATION

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

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

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

1. Notify *you* in writing of the existence and terms of any *pre-existing condition* limitation;
2. Notify *you* of *your* right to request a *certificate of creditable coverage* from any applicable prior plans;
3. Notify *you* of *your* right to submit evidence of *creditable coverage* to the *Plan Manager* to reduce the length of any *pre-existing condition* limitation; and
4. Offer to request a *certificate of prior creditable coverage* on *your* behalf.

Eligibility and Effective Date of Coverage Continued

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

1. Notify *you* in writing of its determination;
2. Notify *you* of the source and substance of any information on which it relied; and
3. Provide an explanation of appeal procedures and allow a reasonable opportunity to submit additional evidence of *creditable coverage*.

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

1. Notifies *you* of such reconsideration in writing disclosing its determination;
2. Notifies *you* with the source and substance of any information on which it relied; and
3. Provides an explanation of appeal procedures and allows a reasonable opportunity to submit additional evidence of *creditable coverage*.

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

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

1. pregnancy;
2. genetic information in the absence of diagnosis;
3. domestic violence; or
4. newborn children, or children adopted before the age of 18, if they are enrolled under the Plan within 60 days of the date of birth, the date the child is legally adopted, or the date the child is legally placed for adoption (or 35 days, if other *dependents* are also being enrolled).

Eligibility and Effective Date of Coverage Continued

SPECIAL PROVISIONS FOR NOT BEING IN ACTIVE STATUS

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

1. No longer than the end of the *pay period* in which a *covered person* is activated during an approved military leave of absence; or
2. No longer than the end of the *pay period* following the approved leave of absence begin date; or
3. No longer than the end of the *pay period* following the approved medical leave of absence (other than FMLA) begin date; or
4. No longer than the end of the *pay period* following the layoff begin date; or
5. No longer than the end of the *pay period* following the period of *total disability* begin date; or
6. No longer than the end of the next *pay period* following the part-time status begin date.

REINSTATEMENT OF COVERAGE FOLLOWING INACTIVE STATUS

If *your* coverage under the Plan was terminated after a period of layoff, *total disability*, or during part-time status, and *you* are now returning to work, *your* coverage is effective the first or the 16th of the month depending on *your* return to work. Both the eligibility period requirement and the *pre-existing condition* limitation will be waived with respect to the reinstatement of *your* coverage. If there is a 63-day lapse in coverage, *pre-existing condition* limitation will be applied.

If *your* coverage under the Plan was terminated after a period of an approved leave of absence without pay, and *you* are now returning to work, *your* coverage is effective the first or the 16th of the month depending on *your* return to work. The eligibility period requirement will be waived and the *pre-existing condition* limitation will be applied with respect to the reinstatement of *your* coverage.

If *your* coverage under the Plan was terminated after a period of an approved military leave of absence (other than USERRA), and *you* are now returning to work, *your* coverage is effective immediately on the day *you* return to work, unless *you* wait until Tricare terminates. If *you* choose to wait until Tricare terminates *you* must sign and date an enrollment application within 35 days of the loss of Tricare. The eligibility Period requirement will be waived and the *pre-existing condition* limitation will be applied with respect to the reinstatement of *your* coverage.

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

Eligibility and Effective Date of Coverage Continued

FAMILY AND MEDICAL LEAVE ACT (FMLA)

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

EXTENDED BENEFITS

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

1. Until coverage for the *total disability* has been obtained under another group policy; or
2. The date *your physician* certifies *you* are no longer *totally disabled*; or
3. The date *you* receive benefits equal to any *maximum benefit* shown on the Schedule of Benefits; or
4. The end of twelve consecutive months immediately following the date of *your* termination of coverage. This period of time is measured from the date *your* coverage is terminated under the *Plan*, to the same calendar day of the next succeeding months.

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

RETIREE COVERAGE

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

SURVIVORSHIP COVERAGE

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

1. for the surviving *dependent spouse*, attaining age 65 and Medicare eligible;
2. for a *dependent* child, the date a limiting age is attained;
3. for any *dependent*, the date eligible for other group insurance;
4. the date this policy terminates or the date the *employer* terminates participation under this Plan.

Eligibility and Effective Date of Coverage Continued

SPECIAL ENROLLMENT

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

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

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

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

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

1. Marriage;
2. Birth; or
3. Adoption or placement for adoption.

You may elect coverage under this Plan provided enrollment is within 35 days from the *qualifying event* or as listed in the Dependent Effective Date of Coverage section. *You* may be required to provide proof that the *qualifying event* has occurred due to one of the reasons listed before coverage under this Plan will be effective. Coverage under this Plan will be effective the 1st day of the month following the signature date of the enrollment form, but not before the event occurs, unless otherwise specified in this section.

Eligibility and Effective Date of Coverage Continued

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

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

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

If *you* apply more than 35 days after a *qualifying event* or as listed in the Dependent Effective Date of Coverage section, *you* are considered a *late applicant* and will not be eligible for coverage under this Plan until the next annual open enrollment period.

Please refer to Exhibit A at the end of this document or see *your employer* for a complete list of permitted family status changes (also referred to as Qualifying Events).

COVERAGE TERMINATION DUE TO PLAN CHANGE

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

1. If a covered *member* is hospitalized when coverage would normally terminate, the prior Insurance Carrier that covered the *member's* hospitalization during the previous plan year would continue coverage until the *member* is released from the *hospital* or transferred to another facility. At the time the *member* is released from the *hospital* or transferred to a new facility, the succeeding Insurance Carrier will assume responsibility for that *member*. It is the *member's* responsibility to ensure that a transfer or re-hospitalization is to a participating facility in compliance with all Plan delivery rules.
2. If a *member* has family coverage and a covered *dependent* is hospitalized when coverage would normally terminate due to a change in Insurance Carriers, the hospitalized family member would continue his/her prior coverage until discharge from the *hospital* or transfer to another facility. All other covered *dependents* not hospitalized at the date the new coverage begins would be transferred to the new Plan on the date the new coverage starts (not on the date the hospitalized *dependent* is released or transferred).
3. If a covered *member* is not at work and/or is on unofficial leave without pay or otherwise continuing to pay for his/her own health insurance premiums on the group coverage, that participant will begin coverage with his/her succeeding Insurance Carrier on January 1, even though he/she is not at work.

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

Eligibility and Effective Date of Coverage Continued

Entitlement to Medicare: if an *employee, spouse, or dependent* who is enrolled in the Plan becomes entitled to coverage (i.e., becomes enrolled) under Part A or Part B of *Medicare*, other than coverage consisting solely of benefits under section 1928 of Social Security Act, the *employee* may make a prospective election change to cancel coverage of that *employee, spouse, or dependent*, under the Plan. In addition, if an *employee, spouse or dependent* who has been entitled to coverage under *Medicare* loses eligibility for such coverage, the *employee* may make a prospective election to commence coverage of that *employee, spouse, or dependent* under the Plan.

Coverage may be elected under this Plan provided enrollment is within 35 days from the entitlement of *Medicare*.

TERMINATION OF COVERAGE

Coverage terminates:

1. The date the Plan terminates;
2. The end of the period for which any required contribution was due and not paid;
3. The end of the semi-monthly billing period* *you* enter full-time military service, except coverage may continue during an approved military leave of absence as indicated in the Special Provisions For Not Being in Active Status provision;
4. The end of the semi-monthly billing period in which *you* fail to be in an eligible class of persons according to the eligibility requirements of the *employer*;
5. For all *employees* at the end of the semi-monthly billing period in which *your* employment terminates;
6. For any benefit, the date the benefit is removed from the Plan;
7. For *your dependents*, the date *your* coverage terminates;
8. For a *dependent*, at the end of the semi-monthly billing period the *dependent* enters full-time military service;
9. For a *dependent*, at the end of the semi-monthly billing period such *covered person* no longer meets the definition of *dependent*; or
10. The end of the semi-monthly billing period *you* request termination of coverage to be effective for yourself and/or *your dependents* based on valid *qualifying event* guidelines.

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

*Semi-monthly billing periods are 1) 1st – 15th and 2) 16th – 31st.

IMPORTANT NOTICE FOR EMPLOYEES AND SPOUSES AGE 65 AND OVER

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

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

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

- Individuals receiving disability benefits from an employer for up to 6 months, or
- Individuals who retain employment rights and have not been terminated by the employer and for whom the employer continues to provide coverage under this Plan. (For example, employees who are on an approved leave of absence.)

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

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

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

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

CONTINUATION OF MEDICAL BENEFITS

THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1986 (COBRA)

CONTINUATION OF BENEFITS

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

ELIGIBILITY

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

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

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

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

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

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

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

COBRA Continued

LOSS OF COVERAGE

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

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

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

NOTICES AND ELECTION

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

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

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

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

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

COBRA Continued

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

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

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

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

MAXIMUM COVERAGE PERIOD

Coverage may continue up to:

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

COBRA Continued

DISABILITY

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

SECOND QUALIFYING EVENT

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

TERMINATION BEFORE THE END OF MAXIMUM COVERAGE PERIOD

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

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

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

COBRA Continued

- The individual on continuation becomes entitled to *Medicare* benefits;
- If there is a final determination under Title II or XVI of the Social Security Act that an individual is no longer disabled; however, continuation coverage will not end until the month that begins more than 30 days after the determination;
- The occurrence of any event (e.g. submission of a fraudulent *claim*) permitting termination of coverage for cause under the Plan.

TYPE OF COVERAGE; PREMIUM PAYMENT

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

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

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

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

OTHER INFORMATION

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

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

COBRA Continued

PLAN CONTACT INFORMATION

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

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

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

CONTINUATION OF BENEFITS

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

ELIGIBILITY

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

PREMIUM PAYMENT

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

DURATION OF COVERAGE

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

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

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

OTHER INFORMATION

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

MEDICAL CONVERSION PRIVILEGE

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

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

1. *Your* coverage ends because *your* employment terminated;
2. *You* are the covered *dependent* former *spouse* or a covered *dependent* child of an *employee* whose marriage ended due to legal annulment, dissolution or divorce;
3. *You* are the surviving *dependent spouse* or child, in the event of the *employee's* death, or at the end of any survivorship continuation provided in the Plan; or
4. *You* have been a covered *dependent* child but no longer meet the definition of *dependent* under the Plan.

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

LIMITATIONS

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

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

DUPLICATION OF COVERAGE

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

COORDINATION OF BENEFITS

BENEFITS SUBJECT TO THIS PROVISION

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

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

1. *Employer*, trustee, union, *employee* benefit, or other association; or
2. Governmental programs, programs mandated by state statute, or sponsored or provided by an educational institution.

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

EFFECT ON BENEFITS

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

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

ORDER OF BENEFIT DETERMINATION

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

1. The plan has no coordination of benefits provision;
2. The plan covers the person as an *employee*;
3. For a child who is covered under both parents' plans, the plan covering the parent whose birthday (month and day) occurs first in the *calendar year* pays before the plan covering the other parent. If the birthdates of both parents are the same, the Plan which has covered the person for the longer period of time will be determined the primary plan;

Coordination of Benefits Continued

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

4. In the case of *dependent* children covered under the plans of divorced or separated parents, the following rules apply:
 - a. The plan of a parent who has custody will pay the benefits first;
 - b. The plan of a step-parent who has custody will pay benefits next;
 - c. The plan of a parent who does not have custody will pay benefits next;
 - d. The plan of a step-parent who does not have custody will pay benefits next.

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

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

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

COORDINATION OF BENEFITS WITH MEDICARE

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

RIGHT OF RECOVERY

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

1. Any person(s) to, for or with respect to whom, such payments were made; or
2. Any other insurance companies, or organizations which according to these provisions, owe benefits due for the same allowable expense under any other plan.

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

REIMBURSEMENT/SUBROGATION

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.

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

1. The Plan 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.

TIME LIMIT ON CERTAIN DEFENSES

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

WORKERS' COMPENSATION NOT AFFECTED

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

WORKERS' COMPENSATION

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

1. The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;
2. No final determination is made that *bodily injury* or *sickness* was sustained in the course of or resulted from *your* employment;
3. The amount of Workers' Compensation due to medical or health care is not agreed upon or defined by *you* or the Workers' Compensation *carrier*;
4. The medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

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

General Provisions Continued

MEDICAID

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

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

CONSTRUCTION OF PLAN TERMS

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

PRIVACY OF PROTECTED HEALTH INFORMATION

The Plan is required by law to maintain the privacy of *your protected health information* in all forms including written, oral and electronically maintained, stored and transmitted information and to provide individuals with notice of the Plan's legal duties and privacy practices with respect to *protected health information*.

The Plan has policies and procedures specifically designed to protect *your* health information when it is in electronic format. This includes administrative, physical and technical safeguards to ensure that *your* health information cannot be inappropriately accessed while it is stored and transmitted to the *Plan Manager* and others that support the Plan.

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.

General Provisions Continued

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 that regard, the *Plan Manager* has been directed that disclosure of *protected health information* to be made to the person(s) identified by the Plan Administrator.

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

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

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

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

CLAIMS PROCEDURES

SUBMITTING A CLAIM

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

- A *claim* must be filed with the *Plan Manager* in writing and delivered to the *Plan Manager*, by mail, postage prepaid.
- *Claims* must be submitted to the *Plan Manager* at the address indicated in the documents describing the Plan or *claimant's* identification card. *Claims* will not be deemed submitted for purposes of these procedures unless and until received at the correct address.
- Also, *claims* submissions must be in a format acceptable to the *Plan Manager* and compliant with any applicable legal requirements. *Claims* that are not submitted in accordance with the requirements of applicable federal law respecting privacy of protected health information and/or electronic *claims* standards will not be accepted by the Plan.
- *Claims* submissions must be timely. *Claims* must be filed as soon as reasonably possible after they are incurred, and in no event later than 15 months after the date of loss, except if *you* were legally incapacitated. Plan benefits are only available for *claims* that are incurred by a *covered person* during the period that he or she is covered under the Plan.
- *Claims* submissions must be complete. They must contain, at a minimum:
 - a. The name of the *covered person* who incurred the *covered expense*;
 - b. The name and address of the health care *provider*;
 - c. The diagnosis of the condition;
 - d. The procedure or nature of the treatment;
 - e. The date of and place where the procedure or treatment has been or will be provided;
 - f. The amount billed and the amount of the *covered expense* not paid through coverage other than Plan coverage, as appropriate;
 - g. Evidence that substantiates the nature, amount, and timeliness of each *covered expense* in a format that is acceptable according to industry standards and in compliance with applicable law.

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

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

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

Claims Procedures Continued

MISCELLANEOUS MEDICAL CHARGES

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

PROCEDURAL DEFECTS

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

ASSIGNMENTS AND REPRESENTATIVES

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

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

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

- Any document designating an authorized representative must be submitted to the *Plan Manager* in advance, or at the time an authorized representative commences a course of action on behalf of a *claimant*. At the same time, the authorized representative should also provide notice of commencement of the action on behalf of the *claimant* to the *claimant*, which the *Plan Manager* may verify with the *claimant* prior to recognizing the authorized representative status.
- In any event, a health care *provider* with knowledge of a *claimant's* medical condition acting in connection with an *urgent care claim* will be recognized by the Plan as the *claimant's* authorized representative.

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

Claims Procedures Continued

CLAIMS DECISIONS

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

PRE-SERVICE CLAIMS

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

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

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

URGENT CARE CLAIMS

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

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

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

- The *claimant* will have a reasonable amount of time, taking into account his or her circumstances, to provide the necessary information but not less than 48 hours.
- The *Plan Manager* will notify the *claimant* of the Plan's *urgent care claim* determination as soon as possible, but in no event more than 48 hours after the earlier of:
 - a. The Plan's receipt of the specified information; or
 - b. The end of the period afforded the *claimant* to provide the specified additional information.

Claims Procedures Continued

CONCURRENT CARE DECISIONS

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

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

POST-SERVICE CLAIMS

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

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

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

TIMES FOR DECISIONS

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

PAYMENT OF CLAIMS

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

Claims Procedures Continued

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

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

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

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

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

INITIAL DENIAL NOTICES

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

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

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

The notice will describe the Plan's review procedures and the time limits applicable to such procedures.

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

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

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

Claims Procedures Continued

APPEALS / GRIEVANCES

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

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

Who Should Perform the Appeal?

Adverse Determination – The *Plan Manager* will handle the Internal Appeal Process for *Adverse Determinations* in accordance with KRS 304.17A-600 through 633.

Coverage Denial – The *Plan Manager* will handle the Internal Appeal Process for Coverage Denials in accordance with KRS 304.17A-600 through 633.

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

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

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

Initial Complaint – a *member* should always contact the *Plan Manager'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 *Plan Manager*, the *member* may file an appeal.

Claims Procedures Continued

Internal Appeal

If the complaint is not resolved to the satisfaction of the *member*, on the initial complaint to the *Plan Manager's* Customer Service Department, the *employee* may request an internal appeal. A request for an internal appeal must be submitted in writing within one hundred eighty (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 *Plan Manager* 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 *Plan Manager* 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 *Plan Manager* agree.

Claims Procedures Continued

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 Department 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 *Plan Manager* must have failed to make a timely determination or notification. In addition, the *member* must have been eligible on the date of *service*, or enrolled and eligible to receive covered benefits under the health benefit plan on the date the service was requested and the treatment or *service* must cost the member at least \$100 if the *member* did not have insurance.

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

The request for an external review must be submitted to the address as listed on page 81. The request must include consent for the *Plan Manager* 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 *Plan Manager*. An extension is available to the IRE if both the *member* and the *Plan Manager* agree in advance.

Expedited External Appeal

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

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

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

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

Claims Procedures Continued

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 Department 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 Department 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.

RIGHT TO REQUIRE MEDICAL EXAMS

(Applies only to medical Plans)

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

EXHAUSTION

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

LEGAL ACTIONS AND LIMITATIONS

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

QUALITY IMPROVEMENT

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

DEFINITIONS

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

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

Advanced imaging, for the purpose of this definition, means Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Positron Emission Tomography (PET), Single Photon Emission Computed Tomography (SPECT) and Computed Tomography (CT) imaging.

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

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

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

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

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

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

Definition Continued

3. Restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one (1) of the following:
 - a. Encompassing preoccupation with one (1) or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus;
 - b. Apparently inflexible adherence to specific, nonfunctional routines or rituals;
 - c. Stereotyped and repetitive motor mannerisms; or
 - d. Persistent preoccupation with parts or objects.
- (B) Delays or abnormal functioning in at least one (1) of the following areas, with onset prior to age three (3) years;
 1. Social interaction;
 2. Language as used in social communication; or
 3. Symbolic or imaginative play; and
- (C) The disturbance is not better accounted for by Rett's Disorder or Childhood Disintegrative Disorder.

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

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

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

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

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

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

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

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

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

Definition Continued

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

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

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

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

Complications of pregnancy means:

1. Conditions whose diagnoses are distinct from pregnancy but adversely affected by pregnancy or caused by pregnancy. Such conditions include: acute nephritis, nephrosis, cardiac decompensation, hyperemesis gravidarum, puerperal infection, toxemia, eclampsia and missed abortion;
2. A nonelective cesarean section surgical procedure;
3. Terminated ectopic pregnancy; or
4. Spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.

Complications of pregnancy does not mean:

1. False labor;
2. Occasional spotting;
3. Prescribed rest during the period of pregnancy;
4. Conditions associated with the management of a difficult pregnancy but which do not constitute distinct *complications of pregnancy*; or
5. An elective cesarean section.

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

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

Definition Continued

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

1. Due to the same *bodily injury* or *sickness*; and
2. Separated by fewer than 30 consecutive days when *you* are not confined.

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

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

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

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

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

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

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

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

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

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

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

1. a group health plan, including church and governmental plans;
2. health insurance coverage;
3. Part A or Part B of Title XVIII of the Social Security Act (Medicare);
4. Medicaid, other than coverage consisting solely of benefits under section 1928 of the Social Security Act;
5. the health plan for active and certain former military personnel, including TRICARE;

Definition Continued

6. the Indian Health Service or other tribal organization program;
7. a state health benefits risk pool;
8. the Federal *Employees Health Benefits Program*;
9. a public health plan as defined in federal regulations;
10. a health benefit plan under Section 5(e) of the Peace Corps Act;
11. any other plan which provides comprehensive *hospital*, medical, and surgical *services* and meets federal requirements; and
12. State Children Health Insurance Program (SCHIP).

Creditable coverage does not include any of the following:

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

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

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

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

Definition 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.

Dependent child eligibility

Pursuant to KRS 304-17A.256, KEHP rules for Unmarried Dependent Children. (For purposes of Health Plan eligibility):

1. Unmarried;
2. Has a specific, family-type relationship to the planholder (a child of the planholder or a descendant of such child; or a brother, sister, stepbrother, or stepsister of the planholder);
3. Planholder is primarily responsible for *dependents* maintenance and support; and
4. Is under age 25.

NOTE: A *dependent* must meet KEHP's eligibility rules before an *employee*/planholder may add the *dependent* to the Plan. Upon reaching age 25, the *dependent* child will become ineligible and be terminated as a *dependent* at the end of the month in which the birthday occurs.

NOTE: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. This includes adding a *dependent* to the Plan who does not meet the KEHP eligibility rules.

Section 125 Cafeteria Plan and 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*/planholder's *dependent(s)* **CANNOT MEET ONE** of these definitions (qualifying child or qualifying relative).

Definition Continued

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

1. A “qualifying child” (QC) of an *employee* under Code § 152, there are four tests—the relationship, residency, age, and limited self-support tests.

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

- Has a specific, family-type relationship to the *member* taxpayer (a child of the *employee* or a descendant of such child; or a brother, sister, stepbrother, or stepsister of the *employee* or a descendant of any such relative). (The relationship test);
- 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). (The residency test);
- Is under age 19 and not a full-time student (or under age 24 if a fulltime student) as of the end of the calendar year in which the *member’s* taxable year begins. A “student” means an individual who, during each of five calendar months during the calendar year in which the *employee’s* taxable year begins, is a full-time student at an educational organization (The age test);
- There is no age requirement if a child is permanently and totally disabled;
- Individual must not provide more than half of his or her own support for the calendar year in which the taxable year of the *employee* begins (The limited self-support test).

2. In order to be a “qualifying relative” (QR) of an *employee* under Code § 152(d), there are three tests—the relationship, support, and not anyone’s qualifying child tests.

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

- Has a specific, family-type relationship to the *member* taxpayer (a child of the *employee* or a descendant of a child of the *employee*, a brother, sister, stepbrother, or stepsister of the *employee*, the father or mother of the *employee*, etc.) and is someone who resides with the *employee* in his/her household for the *member’s* taxable year. (The relationship test);
- 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; (The relationship test);
- Receives over half of his/her own support from the *member*-taxpayer. Support includes food, shelter, clothing, medical and dental care, education, and the like.) (The support test);
- Is not anyone’s (including the *member’s*) “qualifying child.” (See definition above) (The not anyone’s qualifying child test).

NOTE: An individual generally will not be a *dependent* under Code § 152 if he or she is a *dependent* of a Code § 152 *dependent*, a married *dependent* filing a joint tax return, or a citizen or national of a country other than the United States.

Definition Continued

Tax Consequences

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. However, if a *dependent* child fails to meet the requirements of a I.R.C. § 152 qualifying child or qualifying relative he or she may be eligible to be covered as a *dependent* on a post-tax basis pursuant to KEHP plan eligibility defined by KRS 304-17A.256.

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

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

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

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

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

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

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

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

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

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

Employee means a person who is employed by agencies participating in the *Kentucky Employees Health Plan* and eligible to apply for coverage under a *Kentucky Employees Health Plan* or who is a retiree of a state sponsored Retirement System Health Plan. Refer to KRS 18A.225 and KRS 18A.227.

Definition Continued

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

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

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

Experimental, investigational or for research purposes:

Services, supplies, or other care, including treatments, procedures, hospitalizations, drugs, biological products or medical devices, which a Peer Review Panel determines are:

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

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

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

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

Definition Continued

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

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

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

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

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

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

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

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

Definition Continued

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

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

Hospital means an institution which:

1. Maintains permanent full-time facilities for bed care of resident patients;
2. Has a *physician* and surgeon in regular attendance;
3. Provides continuous 24 hour a day nursing *services* by, or under the supervision of, registered nurses;
4. Is primarily engaged in providing diagnostic and therapeutic facilities for medical or surgical care of sick or injured persons under the supervision of a staff of fully licensed *physicians*. No *claim* for payment of treatment, care, or *services* shall be denied because a *hospital* lacks major surgical facilities and is primarily of a rehabilitative nature, if such rehabilitation is specifically for treatment of physical disability;
5. Is legally operated in the jurisdiction where located; and
6. Has surgical facilities on its premises or has a contractual agreement for surgical *services* with an institution having a valid license to provide such surgical *services*; or
7. It is a *hospital* accredited by the Joint Commission on the Accreditation of Healthcare Organizations, the American Osteopathic Association, or the Commission on the Accreditation of Rehabilitative Facilities, or certified by the Kentucky Division of Licensure and Regulation.

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

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

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

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

Definition Continued

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

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

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

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

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

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

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

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

Definition Continued

5. Substantiated by the records and documentation maintained by the *provider of service*.

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

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

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

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

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

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

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

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

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

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

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

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

Definition Continued

Partial hospitalization means *services* provided by a *hospital* or *qualified treatment facility* in which patients do not reside for a full 24-hour period:

1. For a comprehensive and intensive interdisciplinary psychiatric treatment for minimum of 5 hours a day, 5 days per week;
2. That provides for social, psychological and rehabilitative training programs with a focus on reintegration back into the community and admits children and adolescents who must have a treatment program designed to meet the special needs of that age range; and
3. That has physicians and appropriately licensed *mental health* and *substance abuse* practitioners readily available for the emergent and urgent care needs of the patients.

The *partial hospitalization* program must be accredited by the Joint Commission of the Accreditation of Hospitals or in compliance with an equivalent standard.

Licensed drug abuse rehabilitation programs and alcohol rehabilitation programs accredited by the Joint Commission on the Accreditation of Health Care Organizations or approved by the appropriate state agency are also considered to be *partial hospitalization services*.

Partial hospitalization does not include *services* that are for *custodial care* or day care.

Pay period means the 15th of the month or the last day of the month. This term may also be called semi-monthly billing cycle.

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

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

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

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

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

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

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

Definition Continued

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

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

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

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

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

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

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

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

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

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

Definition Continued

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

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

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

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

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

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

Qualifying event means a specific situation or occurrence that enables an *eligible person* to enroll or disenroll outside the designated enrollment period as a result of that person becoming eligible for or losing eligibility for coverage under this group plan or another group plan. *Qualifying events* are governed by 26 C.F.R. § 1.125-4 and Prop.Treas. Reg 1.125-2(a). All applications for *qualifying events* must be signed within 35 days of the *qualifying event* date.

Definition Continued

Registered Nurse First Assistant means a nurse who:

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

A registered nurse who was certified prior to 1995 by the Certification Board of Perioperative Nursing shall not be required to fulfill the requirements of paragraph (3) of this subsection.

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

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

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

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

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

Single coverage means coverage for the *member* only.

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

Definition Continued

Sound natural tooth means a tooth that:

1. Is organic and formed by the natural development of the body (not manufactured);
2. Has not been extensively restored;
3. Has not become extensively decayed or involved in periodontal disease; and
4. Is not more susceptible to injury than a whole natural tooth.

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

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

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

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

Summary Plan Description (SPD) means the document which lists definitions, benefits, exclusions, and other provisions of coverage under the *Plan*.

Surgery means excision or incision of the skin or mucosal tissues, or insertion for exploratory purposes into a natural body opening. This includes insertion of instruments into any body opening, natural or otherwise, done for diagnostic or other therapeutic purposes.

Telehealth services means the use of interactive audio, video, or other electronic media to deliver health care. It includes the use of electronic media for diagnosis, consultation, treatment, transfer of medical data, and medical education. A telehealth consultation shall not be reimbursable if it is provided through the use of an audio-only telephone, facsimile machine, or electronic mail.

Therapy Service means *services*, supplies, or other care used for the treatment of a *sickness* or *bodily injury* to promote the recovery of the patient. *Therapy services* include, but are not limited to:

1. Physical Therapy – The treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, biomechanical and neurophysiological principles and devices to relieve pain, restore maximum function, and prevent disability following disease, *bodily injury* or loss of a body part.
2. Respiratory Therapy – Introduction of dry or moist gases into the lungs for treatment purposes.
3. Speech Therapy – The treatment rendered to restore speech loss due to *sickness* or *bodily injury*.

Definition Continued

4. Cardiac Rehabilitation – Treatment provided to individuals who have suffered a heart attack, have had heart *surgery*, or have other cardiac problems.
5. Occupational Therapy – The treatment program of prescribed activities coordination and mastery, designed to assist a person to regain independence, particularly in the normal activities of daily living.

Timely applicant means an *employee* and/or an *employee's* eligible *dependent* who applies for medical coverage within 30 days of the eligibility date.

Total disability or totally disabled means:

1. During the first twelve months of disability *you* or *your* employed covered *spouse* are at all times prevented by *bodily injury* or *sickness* from performing each and every material duty of *your* respective job or occupation;
2. After the first twelve months, *total disability* or *totally disabled* means that *you* or *your* employed covered *spouse* are at all times prevented by *bodily injury* or *sickness* from engaging in any job or occupation for wage or profit for which *you* or *your* employed covered *spouse* are reasonably qualified by education, training or experience;
3. For a non-employed *spouse* or a child, *total disability* or *totally disabled* means the inability to perform the normal activities of a person of similar age and gender.

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

Urgent care means *services*, supplies or other care that is appropriate to the treatment of a *sickness* or *injury* that is not a life-threatening *emergency*, but requires prompt medical attention. *Urgent care* includes the treatment of minor injuries as a result of accidents, the relief or elimination of severe pain, or the moderation of an acute *illness*.

Urgent care claim means a *claim* for medical care or treatment with respect to which the application of the time periods for making non-*urgent care* determinations:

- Could seriously jeopardize the life or health of the *claimant* or the ability of the *claimant* to regain maximum function; or
- In the opinion of a *physician* with knowledge of the *claimant's* medical condition, would subject the *claimant* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *claim*.
- Generally, whether a *claim* is a *claim* involving *urgent care* will be determined by the *Plan Manager*. However, any *claim* that a *physician* with knowledge of a *claimant's* medical condition determines is a “*claim* involving *urgent care*” will be treated as a “*claim* involving *urgent care*.”

Definition Continued

Utilization review means the process of assessing the *medical necessity*, appropriateness, or utility of *hospital* admissions, surgical procedures, *outpatient* care, and other health care *services*. *Utilization review* includes *precertification* and *concurrent review*.

Waiting Period means the period of time before an individual becomes eligible for coverage under the *plan*.

Wellness Program means educational and clinical *services* designed to improve a *member's* health by promoting healthy behaviors, such as eating well, exercising, and assistance in altering unhealthy behaviors.

You and your means *you* as the *employee* and any of *your* covered *dependents*, unless otherwise indicated.

NOTICE TO ENROLLEES CONCERNING TOBACCO

Under a Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, as amended, group health plans must generally comply with certain requirements. However, the law also permits state and local governmental employers that sponsor health plans to elect to exempt a plan from these requirements for any part of the plan that is “self-funded” by the employer, rather than provided through a health insurance policy. A group health plan may not discriminate in enrollment rules or in the amount of premiums or contributions it requires an individual to pay based on certain health status-related factors: health status, medical condition (physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability. **The sole differentiation among enrollees in the Commonwealth’s Plan relates to the incentive, through a greater employer contribution, offered to enrollees that refrain from the use of tobacco products. No other health-related factors are used to distinguish enrollees.**

NOTICE OF PRIVACY PRACTICES (SUMMARY)

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

This Notice describes the obligations of the Department of 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 of 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.

EXHIBIT A QUALIFYING EVENTS

This Plan has adopted the following qualifying events (i.e. election changes) as permitted by 26 C.F.R § 1-125-4 and Prop. Treas. Reg. § 1.125-2(a)(1). Please contact your employer or insurance coordinator for additional information concerning this Plan's qualifying events.

1. **Change in Status**

Six categories of Change in Status events include:

- change in employee's legal marital status;
- change in number of dependents;
- change in employment status;
- dependent satisfies (or ceases to satisfy) dependent eligibility requirements;
- change in residence; and
- commencement or termination of adoption proceedings

2. **Cost Changes, With Automatic Increases/Decreases in Elective Contributions;**

3. **Significant Cost Changes;**

4. **Significant Coverage Curtailment;**

5. **Addition or Significant Improvement of Benefit Package Option;**

6. **Change in Coverage Under Other Employer Plan;**

7. **Loss of Group Health Coverage Sponsored by Governmental or Educational Institution;**

8. **HIPAA Special Enrollments;**

9. **COBRA Qualifying Events;**

10. **Judgments, Decrees, or Orders;**

11. **Medicare or Medicaid Entitlement; and**

12. **MLA Leaves of Absence.**

Please note that this Plan also allows for election changes related to USERRA and an employee's absence for military service.