Commonwealth of Kentucky
Personnel Cabinet
Department of Employee Insurance

2010 Plan Year
Kentucky Employees' Health Plan Handbook

www.kehp.ky.gov

TABLE OF CONTENTS

GENERAL INFORMATION

Disclaimer

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

Penalties for misrepresentation

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

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

Contact information

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

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

GENERAL INFORMATION (CONTINUED)

If you have questions about:	You need to contact:
• Participating providers • Medical claims • ID cards	Humana Insurance Company and its Affiliates 877 KYSPIRIT (877 597-7474)

• Flexible Spending Account Claims
  ▪ Healthcare FSA claims
  ▪ Dependent Care FSA Claims
• Health Reimbursement Accounts (HRA)
• Humana*Access*℠ Visa® Debit Card
	Humana Spending Account Administration
	800 604-6228
	800 905-1851 (FAX)
	P. O. Box 14167
	Lexington, KY 40512-4167

• Prescription drug formulary • Participating pharmacies • Prescription drug claims • Step Therapy Program • Prior Authorization • CuraScript Specialty Pharmacy • Mail Order Prescription Program	Express Scripts, Inc. 877 KYSPIRIT (877 597-7474)
• Medical or pharmacy benefits • Eligibility • Enrollment • Qualifying Events • Address Changes	Department of Employee Insurance Member Services Branch 502 564-6534 888 581-8834 502 564-5278 FAX

• Flexible Spending Accounts Eligibility
  ▪ Healthcare FSA
  ▪ Dependent Care FSA
• Health Reimbursement Account (HRA)
	Department of Employee Insurance
	Flexible Benefits Branch
	502 564-0350
	502 564-0351
	502 564-0364 FAX

• Humana Health Assessment (HHA) • Informed Care Management Programs • Smoking Cessation Program • Wellness Programs • Health Coaching • Virgin HealthMiles	Department of Employee Insurance Wellness Hotline 877-KEHPWELL (877-534-7935)

AVAILABLE ONLINE RESOURCES

www.kehp.ky.gov

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

- This KEHP Handbook and the Benefits Selection Guide.
- Medical and Pharmacy Summary Plan Descriptions (SPD) – your SPD is your guide to understanding your Plan's covered benefits, limitations and exclusions. Select the SPD for the Plan in which you are enrolled.
- SPDs for Healthcare FSA and Dependent Care FSA – these contain in-depth information regarding these employee funded programs.
- Health Reimbursement Account (HRA) SPD – available for those who waive health insurance coverage through KEHP.
- Information regarding wellness programs and benefits available to KEHP members.
- Useful links to Humana, Express Scripts, Kentucky Retirement Systems and Kentucky Teachers' Retirement System.
- Enrollment forms – such as the Enrollment Application, Dependent Add and Dependent Drop Forms, Update Form, Post-Tax Request Form, Health Reimbursement Account and FSA Claim Form, etc.

www.myhumana.com

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

www.express-scripts.com

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

Note:

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

MEMBER RESPONSIBILITIES

Read all information carefully

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

Plan your decisions wisely

Study the Benefits Grid on pages 18 - 22 to determine which option best suits your and/or your family's needs.

Review the Premium Information on pages 12 - 13 and determine the amount, if any that will be deducted from your paycheck. You can also use KEHP Benefits Analyzer, a pre-enrollment, planning tool. This tool will provide you a personalized, healthcare "cost and use" summary to help you make informed decisions. You can access KEHP Benefits Analyzer through KEHP's Open Enrollment Website: www.kehp.ky.gov. Once you have made your selections during Open Enrollment, you will not be allowed to make changes unless you experience a Qualifying Event that would allow a change, or if you have a break in employment of **11 days or more**. For specific information on Qualifying Events, refer to pages 65-70.

Enroll no later than October 25, 2009.

Open Enrollment is October 12, 2009 through October 25, 2009. **The 2010 Plan Year is a mandatory total enrollment**.

A mandatory total enrollment means that all employees MUST make an election or he/she will not have health insurance, FSA coverage, or an HRA for the 2010 Plan Year.

Verify that your elections are correct

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

MEMBER RESPONSIBILITIES (CONTINUED)

Verify that your deductions are correct

It is your responsibility to review your first check for your 2010 Plan Year deductions. If your deductions do not match the elections you made during Open Enrollment, contact your agency's Insurance Coordinator **immediately**. If the deductions match your elections, no changes will be allowed.

Notify your agency's Insurance Coordinator of any eligibility changes

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

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

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

Review your FSA information

If you are an employee of a state agency, a school board, or certain quasi governmental agencies, you are eligible for participation in KEHP Flexible Spending Account Program. Refer to the Flexible Benefits section in this Handbook for additional information.

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

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

WHAT'S NEW

Beginning January 1, 2010:

- **Mandatory, Active Enrollment**
  Open Enrollment for the 2010 Plan Year will be a mandatory, active enrollment. This means **YOU MUST ENROLL** either on-line or by paper application. We encourage you to enroll on-line; however, retirees must work through their retirement systems.

  None of your current benefits will automatically "roll over" to the 2010 Plan Year.

- **Virgin HealthMiles: Sign Up for Discounted Rates by October 31**
  Since January, Virgin HealthMiles has offered KEHP members an exclusive discount arrangement on Virgin's popular $150, $300 and $500 Rewards packages. Under the discount arrangement, KEHP members receive at least 50% off the regular price of each Rewards package. To date, nearly 7,000 KEHP members have taken advantage of this special deal!

  The last day to sign up for the discount arrangement is October 31, 2009. KEHP members enrolling in a Rewards package by that date will continue to receive the monthly discount for 12 months after the date of enrollment. Don't let this opportunity pass you by!

- **Virgin HealthMiles: More Prizes, More Chances to Win**
  KEHP is pleased to announce it will soon increase the number of prizes awarded in our monthly Virgin HealthMiles HealthCash drawings. More prizes mean more chances to win!

  Starting with the January, 2010 drawing (held in early February), each month KEHP will offer 207 prizes totaling $21,000:

  - 2 prizes of $500 each
  - 30 prizes of $250 each
  - 75 prizes of $100 each
  - 100 prizes of $50 each

- **Enhancements to KEHP Benefit Plans**
  Effective January 1, 2010, KEHP will offer a number of benefit enhancements:
  - **Preventive Colonoscopy** – The removal of polyps during a preventive (routine) colonoscopy will be charged as a preventive procedure rather than being billed as separate diagnostic or surgical charges on all KEHP benefit plans.

  - **Commonwealth Capitol Choice Benefit Allowance** – After a member pays his or her physician office visit co-pay, the remaining cost of the physician office visit will be paid by KEHP without being deducted from the member's $500 Up-Front, Benefit Allowance.

  - **Commonwealth Standard PPO Deductibles** – In-network deductible for Single coverage will be reduced from $750 to

$500 with $0 employee contribution. The premiums for other levels of coverage in this plan have also been dramatically reduced with no loss of benefits.

- **Other Changes in KEHP Benefit Plans**
  Other changes in KEHP benefit plans for 2010 will include:
  - **Physician Office Visit Co-Pays** – The physician office visit co-pays will increase just $5 for Specialists in the Commonwealth Optimum PPO and Commonwealth Capitol Choice plans. Physician office visit co-pays for Primary Care Physicians (PCPs) will not change. PCPs include general practitioners, family practitioners, internists, pediatricians, chiropractors, and OB/GYNs. KEHP co-pays remain among the lowest available anywhere.

- **KEHP Wellness Hotline – 877-KEHPWELL (877-534-7935)**
  Have you ever thought about having your own, personal health coach to help you increase your activity level, stop smoking, lose weight or better manage a chronic condition? Not sure who to call? Beginning October 1, 2009, KEHP will offer the KEHP Wellness Hotline — a toll-free, telephone number with "one-stop shopping" for KEHP wellness services.

  Programs available through KEHP Wellness Hotline will include health risk assessments by Humana; health coaching by LifeSynch; disease management by ActiveHealth Management; Virgin HealthMiles; Cooper-Clayton Smoking Cessation; the Kentucky Quit Line; and Why Weight Kentucky.

OPEN ENROLLMENT

Open Enrollment dates

Open Enrollment is October 12 - October 25, 2009. You must enroll online or complete and sign your Enrollment Application and submit it to your agency's Insurance Coordinator by October 25, 2009.

Is it required that I enroll for 2010?

YES. **The 2010 Open Enrollment is a MANDATORY TOTAL ENROLLMENT, which means it is a requirement for all employees to enroll during Open Enrollment for the 2010 Plan Year.** Every employee must enroll, regardless of whether you are enrolled in a health insurance plan, you waive your health insurance and have a Health Reimbursement Account, or you have a Flexible Spending Account.

You may enroll online, unless you are:

- A retiree;
- Paying by cross-reference with a retiree;
- A retiree who has returned to work;
- A new employee who has not yet enrolled for 2009, in which case you need to first enroll online for 2009, then enroll again to complete your 2010 enrollment; or
- Switching the "primary" planholder on a cross-reference payment option.

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

BENEFIT FAIRS

The dates, times, and locations of this year's 18 KEHP Benefit Fairs are listed below. Representatives from the Kentucky Department of Employee Insurance, Humana and Express Scripts will be available at each Benefit Fair to answer any questions you may have about Open Enrollment for 2010. Attend the Benefit Fair closest to you!

This year, certain Benefit Fairs will feature **computer kiosks** for active employees (on a "first-come, first-served" basis) who need assistance (1) using KEHP's new, on-line, pre-enrollment planning tool, the "KEHP Benefits Analyzer"; or (2) enrolling on-line through KEHP's "Web Enrollment" system. Benefit Fairs offering **computer kiosks** are indicated below.

Oct. 1
Franklin County
8:00 a.m. – 6:00 p.m.
Frankfort Convention Center
405 Mero Street
Frankfort, KY 40601

Oct. 1
Boyd County
2:00 p.m. – 6:00 p.m.
Boyd County Middle School Theater
1226 Summit Road
Ashland, KY 41112

Oct. 5
McCracken County
2:00 p.m. – 6:00 p.m.
Western KY Comm. & Tech. College
Crounse Hall Atrium
4810 Alben Barkley Drive
Paducah, KY 42001

Oct. 5
Kenton County
2:00 p.m. – 6:00 p.m.
Northern KY Area Development District
22 Spiral Drive
Florence, KY 41022

Oct. 6
Calloway County
2:00 p.m. – 6:00 p.m.
Calloway County Board of Education
Board Meeting Room
2110 College Farm Road
Murray, KY 42071

Oct. 6
Rowan County
2:00 p.m. – 6:00 p.m.
Rowan County Board of Education
Central Office Board Room
121 East 2nd Street
Morehead, KY 40351

Oct. 7
Christian County
2:00 p.m. – 6:00 p.m.
Christian County Board of Education
Board Room
200 Glass Avenue
Hopkinsville, KY 42240

Oct. 7
Boyle County
2:00 p.m. – 6:00 p.m.
Inter-County Energy Cooperative
1009 Hustonville Road
Danville, KY 40422

BENEFIT FAIRS

Oct. 8
Hopkins County
2:00 p.m. – 6:00 p.m.
Madisonville North Hopkins High School Library
4515 Hanson Road
Madisonville, KY 42431

Oct. 8
Madison County
2:00 p.m. – 6:00 p.m.
Madison Central High School Cafeteria
705 North Second Street
Richmond, KY 40475

Oct. 12 (Computer Kiosks)
Floyd County
2:00 p.m. – 6:00 p.m.
Prestonsburg Elementary Library
140 South Clark Road
Prestonsburg, KY 41653

Oct. 12 (Computer Kiosks)
Pulaski County
2:00 p.m. – 6:00 p.m.
The Center for Rural Development
2292 Highway 27 South
Somerset, KY 42501

Oct. 13 (Computer Kiosks)
Warren County
2:00 p.m. – 6:00 p.m.
Greenwood High School Library
5065 Scottsville Road
Bowling Green, KY 42104

Oct. 13 (Computer Kiosks)
Laurel County
2:00 p.m. – 6:00 p.m.
G.C. Garland Administration Building
London Elementary School Campus
710 North Main Street
London, KY 40741

Oct. 14 (Computer Kiosks)
Fayette County
4:00 p.m. – 8:00 p.m.
Dunbar High School Cafeteria
1600 Man-O-War Boulevard
Lexington, KY 40513

Oct. 14 (Computer Kiosks)
Daviess County
2:00 p.m. – 6:00 p.m.
Fairfield Inn Conference Room
800 Salem Drive
Owensboro, KY 42303

Oct. 15
Jefferson County
8:00 a.m. – 6:00 p.m.
Kentucky Fair & Exposition Center
West Hall Mtg Rooms 1 & 2
Louisville, KY 40233

Oct. 15 (Computer Kiosks)
Nelson County
2:00 p.m. – 6:00 p.m.
Nelson County High Library
1070 Bloomfield Road
Bardstown, KY 40004

PREMIUM INFORMATION

Premium conversion – (does not apply to retirees)

Upon enrollment, you are automatically set up to have your health insurance premiums deducted on a pre-tax basis (except for covered dependents that will automatically be covered on a post-tax basis. Please refer to page 59 for details). If you do not wish to have premiums deducted on a pre-tax basis, you must sign the "Post Tax Request Form". You may find this form on our web site at www.kehp.ky.gov, or you may contact the Department of Employee Insurance.

PREMIUM INFORMATION (CONTINUED)

Non-Smoker Rates

Commonwealth Standard PPO

	Total Premium	Employer Contribution	Employee Contribution
Single	$486.40	$486.40	$0.00
Parent Plus	$749.84	$741.56	$8.28
Couple	$1,127.80	$845.62	$282.18
Family	$1,253.56	$965.12	$288.44
Family Cross-Reference**	$626.78	$626.78	$0.00

Commonwealth Capitol Choice

	Total Premium	Employer Contribution	Employee Contribution
Single	$594.14	$589.14	$5.00
Parent Plus	$896.06	$752.04	$144.02
Couple	$1,347.50	$903.38	$444.12
Family	$1,490.60	$964.76	$525.84
Family Cross-Reference**	$745.30	$732.42	$12.88

Commonwealth Optimum PPO

	Total Premium	Employer Contribution	Employee Contribution
Single	$616.28	$588.78	$27.50
Parent Plus	$889.54	$713.02	$176.52
Couple	$1,363.40	$893.88	$469.52
Family	$1,515.36	$954.20	$561.16
Family Cross-Reference**	$757.68	$729.34	$28.34

Commonwealth Maximum Choice

	Total Premium	Employer Contribution	Employee Contribution
Single	$575.42	$575.42	$0.00
Parent Plus	$851.46	$742.60	$108.86
Couple	$1,177.68	$843.02	$334.66
Family	$1,341.52	$943.20	$398.32
Family Cross-Reference**	$670.76	$661.10	$9.66

If either employee in a Family Cross-Reference Plan is a smoker, both employees are subject to the monthly Smoker Rates.

PREMIUM INFORMATION (CONTINUED)

Smoker Rates

Commonwealth Standard PPO

	Total Premium	Employer Contribution	Employee Contribution
Single	$486.40	$462.40	$24.00
Parent Plus	$749.84	$693.56	$56.28
Couple	$1,127.80	$797.62	$330.18
Family	$1,253.56	$917.12	$336.44
Family Cross-Reference**	$626.78	$602.78	$24.00

Commonwealth Capitol Choice

	Total Premium	Employer Contribution	Employee Contribution
Single	$594.14	$565.14	$29.00
Parent Plus	$896.06	$704.04	$192.02
Couple	$1,347.50	$855.38	$492.12
Family	$1,490.60	$916.76	$573.84
Family Cross-Reference**	$745.30	$708.42	$36.88

Commonwealth Optimum PPO

	Total Premium	Employer Contribution	Employee Contribution
Single	$616.28	$564.78	$51.50
Parent Plus	$889.54	$665.02	$224.52
Couple	$1,363.40	$845.88	$517.52
Family	$1,515.36	$906.20	$609.16
Family Cross-Reference**	$757.68	$705.34	$52.34

Commonwealth Maximum Choice

	Total Premium	Employer Contribution	Employee Contribution
Single	$575.42	$551.42	$24.00
Parent Plus	$851.46	$694.60	$156.86
Couple	$1,177.68	$795.02	$382.66
Family	$1,341.52	$895.20	$446.32
Family Cross-Reference**	$670.76	$637.10	$33.66

If either employee in a Family Cross-Reference Plan is a smoker, both employees are subject to the monthly Smoker Rates.

PREMIUM INFORMATION (CONTINUED)

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

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

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

The exemption from this Federal requirement will be in effect for the 2010 Plan Year beginning January 1, 2010, and ending December 31, 2010. The election will be renewed for subsequent plan years.

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

HEALTH INSURANCE PLAN OPTIONS

What are My Plan Choices?

Different individuals have different Healthcare needs. For this reason, KEHP will offer four different health plan choices during the 2010 Plan Year.

Two of the four KEHP plans feature a $0 employee contribution for single coverage. While you are free to choose where to receive your medical care, all four plans offer an opportunity to save money by utilizing an extensive network of preferred providers. None of the four plans require referrals for treatment.

All four plans feature **100% coverage for most or all preventive services.** All four plans also feature low**, annual, out-of-pocket maximums** and **unlimited lifetime maximums**. Regardless of which KEHP plan you choose, you will have a comfortable **safety net** in the event of a chronic or catastrophic condition.

How Do I Choose a Plan?

There are several factors to consider when choosing a health benefit plan. To begin with, you should consider how much money will be deducted from your paycheck(s) on a monthly and annual basis to pay for the plan. **The employee contributions are sometimes referred to as your "out-of-paycheck" costs.**

You should also consider how much additional money you will have to pay in the event you receive medical care. **These expenses are sometimes referred to as your "out-of-pocket" costs.** To determine your out-of-pocket costs, you need to estimate the dollar amount(s) of all medical and pharmacy expenses you expect to incur during the 2010 Plan Year.

A brief overview of each of the four 2010 KEHP benefit plans are presented below:

COMMONWEALTH MAXIMUM CHOICE

Commonwealth Maximum Choice is a consumer-driven plan that includes a KEHP-funded, Health Reimbursement Account (HRA). KEHP contributes $1,000 for Single coverage, $1,500 for Parent Plus and Couple coverage, and $2,000 for Family coverage into your HRA.

Commonwealth Maximum Choice is a good choice for people at both ends of the healthcare spectrum: people who are healthy and have few, if any, medical expenses; and people who have chronic or other significant medical conditions with above-average expenses.

According to our actuaries, this plan has the richest benefits of any KEHP plan. At the same time, it has the second lowest employee contributions in the program. If you choose this plan, you will enjoy substantial "out-of-paycheck" savings throughout the Plan Year. Although the plan includes higher, initial, out-of-pocket costs, the monies funded by KEHP into your HRA can help offset those costs. For example, for Single Coverage, the money in your HRA may be used to cover the first $1,000 in out-of-pocket costs. This has the effect of lowering

your Annual Deductible to $1,000. Once the deductible is met, the plan pays 90% of most in-network expenses until you reach your annual, out-of-pocket maximum; and since the plan does not have Co-Pays, all covered expenses apply to the annual, out-of-pocket maximum. Also, preventive screenings (such as well child care and well adult care) are covered at 100%.

If you chose Commonwealth Maximum Choice in 2009, you will "roll over" any unused 2009 HRA funds if you continue with the same plan for the 2010 Plan Year. However, if you chose the Commonwealth Maximum Choice Plan in 2009 and elect a different plan in 2010, any funds remaining in your 2009 HRA WILL NOT roll over.

Due to the nature of the HRA accompanying this plan, RETIREES ARE NOT ELIGIBLE to participate in the Commonwealth Maximum Choice Plan.

COMMONWEALTH OPTIMUM PPO

Commonwealth Optimum PPO is a traditional Preferred Provider Organization (PPO) plan. This plan is a good choice if you are willing to have larger paycheck deductions in exchange for lower out-of-pocket costs. As with all KEHP plans, you pay less when you use in-network providers. The plan also provides coverage when you use out-of-network providers, but you will pay more.

Commonwealth Optimum PPO offers the peace of mind of knowing you have fixed, predictable co-pays for physician office visits, prescription medications, and various other services.

COMMONWEALTH CAPITOL CHOICE

Commonwealth Capitol Choice is a unique, hybrid health plan that combines features of a consumer-driven plan with a traditional PPO plan. With this plan, KEHP will fund a $500 per family member "benefit allowance" that provides 100% coverage for many in-network services before you start paying towards your deductible. (Note: the $500 is a benefit allowance, not an HRA, so it cannot be "rolled over" from year to year.)

Commonwealth Capitol Choice should work especially well for people with annual medical expenses below $500, and people looking for a plan with excellent inpatient hospital facility benefits.

Commonwealth Capitol Choice offers predictable office visit and pharmacy co-pays, similar to a traditional PPO. Another valuable feature of Commonwealth Capitol Choice is the $100 per admission, hospital facility co-pay. After payment of the $100 per admission co-pay and a $500 annual deductible, you pay nothing for additional hospital facility charges. (Note: you will be responsible for charges related to physician and other services while in the hospital.)

COMMONWEALTH STANDARD PPO

Commonwealth Standard PPO is a value-based, traditional PPO plan. Although it features higher deductibles, higher member co-insurance percentages, and higher annual out-of-

pocket maximums than the Commonwealth Optimum PPO, it offers much lower premiums.

Commonwealth Standard PPO is a good choice for people who are mainly interested in a good, basic plan to provide catastrophic coverage and people who want dependent coverage at a lower price.

KEHP 2010 Benefits Grid

Benefit	Commonwealth Standard PPO		Commonwealth Capitol Choice		Commonwealth Optimum PPO		Commonwealth Maximum Choice	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Up-Front Benefit Allowance	Not Applicable	Not Applicable	$500 per Family Member	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Annual Deductible	Single - $500 Family - $1,500	Single - $1,500 Family - $3,000	Single - $500 Family - $1,500	Single - $1,000 Family - $3,000	Single - $300 Family - $600	Single - $600 Family - $1,200	Single - $2,000 Family - $3,000	Single - $2,000 Family - $3,000
Co-insurance	Plan pays - 75% You pay - 25%	Plan pays - 50% You pay - 50%	Plan pays - 80% You pay - 20%	Plan pays - 60% You pay - 40%	Plan pays - 85% You pay - 15%	Plan pays - 70% You pay - 30%	Plan pays - 90% You pay - 10%	Plan pays 60% You pay - 40%
Annual Out-of-Pocket Maximum	Single - $3,500 Family - $7,000	Single - $7,000 Family - $14,000	Single - $2,000 Family - $6,000	Single - $4,000 Family - $12,000	Single – $1,125 Family - $2,250	Single - $2,250 Family - $4,500	Single - $3,000 Family - $4,500	Single - $4,000 Family - $6,000
	Excludes prescription drug expenses and emergency room co-pays.		Excludes prescription drug co-pays, and all other co-pays		Excludes prescription drug co-pays, and all other co-pays		All covered expenses apply to the out-of-pocket maximum	
Health Reimbursement Account Funds	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Single - $1,000 Parent Plus $1,500 Couple - $1,500 Family - $2,000 Cross Reference - $2,000	
	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays
Hospital Services								
Inpatient Hospital (semi-private room	Deductible then 25%*	Deductible then 50%*	$100 co-pay per Admit plus Deductible then 0%*	Deductible then 40%*	Deductible then 15%*	Deductible then 30%*	Deductible then 10%*	Deductible then 40%*
Outpatient Surgery	Deductible then 25%*	Deductible then 50%*	$50 co-pay plus Deductible then 0%*	Deductible then 40%*	Deductible then 15%	Deductible then 30%*	Deductible then 10%*	Deductible then 40%*
Outpatient Diagnostic X-ray and Lab	Deductible then 25%*	Deductible then 50%*	Deductible then 20%*	Deductible then 40%*	$10 per provider/ member/site	Deductible then 30%*	Deductible then 10%*	Deductible then 40%*
Pre-admission Testing	Deductible then 25%*	Deductible then 50%*	Pay 0%	Pay 0%	$10 co-pay	Deductible then 30%*	Deductible then 10%*	Deductible then 40%*
Emergency Room	$50 co-pay then Deductible and 25%*	$50 co-pay then Deductible and 50%*	$100 co-pay plus Deductible then 0%	$100 co-pay plus Deductible then 0%	$75 co-pay plus 15%*	$75 co-pay then Deductible plus 30%*	Deductible then 10%*	Deductible then 40%*
	Co-pay waived if admitted		Co-pay waived if admitted		Co-pay waived if admitted			

KEHP 2010 Benefits Grid								
Benefit	Commonwealth Standard PPO		Commonwealth Capitol Choice		Commonwealth Optimum PPO		Commonwealth Maximum Choice	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Emergency Room Physician	Deductible then 25%*	Deductible then 50%*	Deductible then 0%*	Deductible then 0%*	15%*	Deductible then 30%*	Deductible then 10%*	Deductible then 40%*
Other Facility Services								
Free Standing Surgical Facility	Deductible then 25%*	Deductible then 50%*	$50 co-pay plus 0%	Deductible then 40%*	Deductible then 15%*	Deductible then 30%*	Deductible then 10%*	Deductible then 40%*
Urgent Care Facility	Deductible then 25%*	Deductible then 50%*	$50 co-pay plus 0%	Deductible then 40%*	$20 co-pay	Deductible then 30%*	Deductible then 10%*	Deductible then 40%*
Physician Services								
Primary Care Physician (PCP) Office Visits	Deductible then 25%*	Deductible then 50%*	$15 co-pay	Deductible then 40%*	$10 co-pay	Deductible then 30%*	Deductible then 10%*	Deductible then 40%*
Specialist Office Visits	Deductible then 25%*	Deductible then 50%*	$20 co-pay	Deductible then 40%*	$15 co-pay	Deductible then 30%*		
Qualified Practitioner (Other than Office Visits)	Deductible then 25%*	Deductible then 50%*	Deductible then 20%*	Deductible then 40%*	Deductible then 15%*	Deductible then 30%*	Deductible then 10%*	Deductible then 40%*
Injections (other than routine)	Deductible then 25%*	Deductible then 50%*	$5 co-pay plus 0%	Deductible then 40%*	$10 co-pay	Deductible then 30%*	Deductible then 10%*	Deductible then 40%*
Diagnostic X-ray and Lab								
Office Setting (same site/same day as office visit)	Deductible then 25%*	Deductible then 50%*	Office visit co-pay then 0%	Deductible then 40%*	Office visit co-pay then 0%	Deductible then 30%*	Deductible then 10%*	Deductible then 40%*
Independent Lab and X-ray	Deductible then 25%*	Deductible then 50%*	Deductible then 20%*	Deductible then 40%*	Office visit co-pay then 0%	Deductible then 30%*	Deductible then 10%*	Deductible then 40%*
Outpatient Hospital X-Ray	Deductible then 25%*	Deductible then 50%*	Deductible then 20%*	Deductible then 40%*	$10 co-pay	Deductible then 30%*	Deductible then 10%*	Deductible then 40%*
Emergency Room Setting	Deductible then 25%*	Deductible then 50%*	Deductible then 0%* after ER co-pay	Deductible then 40%*	Deductible then 15%* after ER co-pay	Deductible then 30%* after ER co-pay	Deductible then 10%*	Deductible then 40%*
Anesthesia and Surgery Services								
Office or Clinic Setting	Deductible then 25%*	Deductible then 50%*	Office visit co-pay then 0%	Deductible then 40%*	Office visit co-pay then 0%	Deductible then 30%*	Deductible then 10%*	Deductible then 40%*
Inpatient or Outpatient Setting	Deductible then 25%*	Deductible then 50%*	Deductible then 20%*	Deductible then 40%*	Deductible then 15%*	Deductible then 30%*	Deductible then 10%*	Deductible then 40%*
Routine Child Care Ages 0 - 18								
Exam and Immunizations	Pay 0%	Pay 0%	Office visit co-pay then pay 0%	Deductible then 40%*	Office visit co-pay	Deductible then 30%*	Pay 0%	Not Covered

KEHP 2010 Benefits Grid								
Benefit	**Commonwealth Standard PPO**		**Commonwealth Capitol Choice**		**Commonwealth Optimum PPO**		**Commonwealth Maximum Choice**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Lab and X-ray (same site/same day as office visit)	Pay 0%	Pay 0%	Pay 0%	Deductible then 40%*	Pay 0%	Deductible then 30%*	Pay 0%	Not Covered
Routine Adult Care Ages 18 and older								
Exam and Testing	Pay 0%	Pay 0%	Office visit co-pay then pay 0%	Deductible then 40%*	Office visit co-pay	Deductible then 30%*	Pay 0%	Not Covered
Lab and X-ray (same site/same day as office visit)	Pay 0%	Pay 0%	Pay 0%	Deductible then 40%*	Pay 0%	Deductible then 30%*	Pay 0%	Not Covered
Inpatient Newborn Benefits								
Well Newborn	Deductible then 25%*	Deductible then 50%*	Pay 0%	Deductible then 40%*	15% coinsurance*	30% coinsurance*	Deductible then 10%*	Deductible then 40%*
Sick Newborn	Deductible then 25%*	Deductible then 50%*	Pay 0%	Deductible then 40%*	Deductible then 15%*	Deductible then 30%*	Deductible then 10%*	Deductible then 40%*
Maternity Care								
Prenatal Care, Labor, Delivery, Postpartum Care, and One Ultrasound per Pregnancy (additional ultrasounds subject to prior plan approval)	Deductible then 25%*	Deductible then 50%*	$15 co-pay (limited to office visit in which pregnancy is diagnosed). Delivery charge: Deductible then 20%*; Facility charge: $100 co-pay per admit plus Deductible	Deductible then 40%*	$10 co-pay (limited to office visit in which pregnancy is diagnosed). Delivery charge subject to Deductible then 15%*	Deductible then 30%*	Deductible then 10%*	Deductible then 40%*
Chemotherapy and Radiation Therapy								
Office or Clinic Setting	Deductible then 25%*	Deductible then 50%*	Deductible then 20%*	Deductible then 40%*	$15 co-pay	Deductible then 30%*	Deductible then 10%*	Deductible then 40%*
Outpatient Hospital Setting	Deductible then 25%*	Deductible then 50%*	Deductible then 20%*	Deductible then 40%*	Deductible then 15%*	Deductible then 30%*	Deductible then 10%*	Deductible then 40%*
Miscellaneous Benefits								
Autism Service	$500 monthly maximum		$500 monthly maximum		$500 monthly maximum		$500 monthly maximum	
Rehabilitative and Therapeutic Care Services	Deductible then 25%*	Deductible then 50%*	Deductible then 20%*	Deductible then 40%*	$15 co-pay	Deductible then 30%*	Deductible then 10%*	Deductible then 40%*
	Therapy services for autism are payable under the specific therapy benefit first and once those limits are exhausted, services are covered under the autism benefit.							

KEHP 2010 Benefits Grid

Benefit	Commonwealth Standard PPO		Commonwealth Capitol Choice		Commonwealth Optimum PPO		Commonwealth Maximum Choice	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Respite Care Children Ages 2 through 21	Deductible then 25%*	Deductible then 50%*	Deductible then 20%*	Deductible then 40%*	Deductible then 15%*	Deductible then 30%*	Deductible then 10%*	Deductible then 40%*
Ambulance Services	Deductible then 25%*	Deductible then 25%*	Deductible then 20%*	Deductible then 20%*	Deductible then 15%*	Deductible then 15%*	Deductible then 10%*	Deductible then 10%*
Skilled Nursing Facility	Deductible then 25%*	Deductible then 50%*	Deductible then 20%*	Deductible then 40%*	Deductible then 15%*	Deductible then 30%*	Deductible then 10%*	Deductible then 40%*
	Maximum of 30 days per calendar year		Maximum of 30 days per calendar year		Maximum of 30 days per calendar year		Maximum of 30 days per calendar year	
Home Health Care	Deductible then 25%*	Deductible then 50%*	Deductible then 20%*	Deductible then 40%*	Deductible then 15%*	Deductible then 30%*	Deductible then 10%*	Deductible then 40%*
	Maximum of 60 visits per calendar year		Maximum of 60 visits per calendar year		Maximum of 60 visits per calendar year		Maximum of 60 visits per calendar year	
Hospice Care	Same as Medicare		Same as Medicare		Same as Medicare		Same as Medicare	
Physical Therapy	Deductible then 25%*	Deductible then 50%*	Deductible then 20%*	Deductible then 40%*	Deductible then 15%*	Deductible then 30%*	Deductible then 10%*	Deductible then 40%*
	Maximum of 30 visits per calendar year		Maximum of 30 visits per calendar year		Maximum of 30 visits per calendar year		Maximum of 30 visits per calendar year	
Occupational Therapy	Deductible then 25%*	Deductible then 50%*	Deductible then 20%*	Deductible then 40%*	Deductible then 15%*	Deductible then 30%*	Deductible then 10%*	Deductible then 40%*
	Maximum of 30 visits per calendar year		Maximum of 30 visits per calendar year		Maximum of 30 visits per calendar year		Maximum of 30 visits per calendar year	
Speech Therapy	Deductible then 25%*	Deductible then 50%*	Deductible then 20%*	Deductible then 40%*	Deductible then 15%*	Deductible then 30%*	Deductible then 10%*	Deductible then 40%*
	Maximum of 30 visits per calendar year		Maximum of 30 visits per calendar year		Maximum of 30 visits per calendar year		Maximum of 30 visits per calendar year	
Cardiac Rehabilitation Therapy (Phase I and II)	Deductible then 25%*	Deductible then 50%*	Deductible then 20%*	Deductible then 40%*	Deductible then 15%*	Deductible then 30%*	Deductible then 10%*	Deductible then 40%*
	Maximum of 30 visits per calendar year		Maximum of 30 visits per calendar year		Maximum of 30 visits per calendar year		Maximum of 30 visits per calendar year	
Rehabilitation Centers	Deductible then 25%*	Deductible then 50%*	Deductible then 20%*	Deductible then 40%*	Deductible then 15%*	Deductible then 30%*	Deductible then 10%*	Deductible then 40%*
Hearing Aids (Covered persons under 18 years of age)	Deductible then 25%*	Deductible then 50%*	Deductible then 20%*	Deductible then 40%*	Deductible then 15%*	Deductible then 30%*	Deductible then 10%*	Deductible then 40%*
	One hearing aid per ear every three years, up to a maximum benefit of $1,400 per ear		One hearing aid per ear every three years, up to a maximum benefit of $1,400 per ear		One hearing aid per ear every three years, up to a maximum benefit of $1,400 per ear		One hearing aid per ear every three years, up to a maximum benefit of $1,400 per ear	
Chiropractor, Exam, Therapy,	Deductible then 25%*	Deductible then 50%*	$15 co-pay plus 0%	Deductible then 40%*	$10 co-pay	Deductible then 30%*	Deductible then 10%*	Deductible then 40%*

KEHP 2010 Benefits Grid										
Benefit	**Commonwealth Standard PPO**			**Commonwealth Capitol Choice**		**Commonwealth Optimum PPO**		**Commonwealth Maximum Choice**	
	In-Network		**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Manipulations	Maximum of 26 visits per calendar year, no more than 1 visit per day.			Maximum of 26 visits per calendar year, no more than 1 visit per day.		Maximum of 26 visits per calendar year, no more than 1 visit per day.		Maximum of 26 visits per calendar year, no more than 1 visit per day.	
Durable Medical Equipment (rental up to purchase price)	Deductible then 25%*		Deductible then 50%*	Deductible then 20%*	Deductible then 40%*	Deductible then 15%*	Deductible then 30%*	Deductible then 10%*	Deductible then 40%*
Prescription Drugs									
Retail Pharmacy 30 day supply									
	25%								
	Min	Max							
1st Tier	$10	$25		$5		$5	30%	Deductible then 10%*	Deductible then 40%*
2nd Tier	$20	$50		$20**		$20**	30%	Deductible then 10%*	Deductible then 40%*
3rd Tier	$35	$100		$40**		$40**	30%	Deductible then 10%*	Deductible then 40%*
Mail Order (90 day supply)									
	25%								
	Min	Max							
1st Tier	$20	$50		$10		$10		Deductible then 10%*	
2nd Tier	$40	$100		$40		$40		Deductible then 10%*	
3rd Tier	$70	$200		$80		$80		Deductible then 10%*	

* Applies to out-of-pocket maximum.

** After the 75th prescription has been filled, excluding mail order, the co-payment will reduce to $15 2nd tier and $30 3rd tier.

The Department for Employee Insurance has made every attempt to ensure the accuracy of the benefits outlined in this Benefits Grid. However, if an error has occurred, the benefits outlined in the 2010 Summary Plan Description will determine how benefits are paid.

EXCLUSIONS

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

- Pre-existing conditions to the extent specified on page 24;
- Services, supplies and other care for acupuncture, anesthesia by hypnosis or anesthesia charges for services not covered by the Plan;
- Services, supplies, or other care for cosmetic surgery, and/or complications arising directly from the cosmetic services;
- Custodial care services, supplies, or other care rendered by or in (a) rest homes; (b) health resorts; (c) homes for the aged; (d) places primarily for domiciliary or custodial care; and (e) self-help training or other forms of non-medical care;
- Dental services (except as outlined in the SPD), 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);
- Any service which is experimental, investigational or for research purposes;
- All fertility testing or services (other than diagnostic testing or services), including any artificial means to achieve pregnancy or ovulation, such as artificial insemination, in vitro fertilization, etc.;
- Services not medically necessary for diagnosis and/or treatment of a bodily injury or sickness;
- Physical exams/immunizations (except as otherwise provided) services, supplies, or other care for routine or periodic physical examinations; immunization or tests for screening purposes required by third parties, such as for employment, school, insurance, marriage, adoption, participation in athletics or services conducted for medical research or examinations required by a court;
- Services and/or drugs related to the treatment and/or diagnosis of sexual dysfunction/impotence, including penile implants; and
- Services for the treatment of obesity, except as specifically indicated in the Summary Plan Description.

For additional exclusions, refer to the SPD. The SPD is on KEHP web site at www.kehp.ky.gov.

GENERAL BENEFITS INFORMATION

Pre-existing conditions

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

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

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

Providers

Provider directories are subject to change throughout the year. Although your physician may be participating with Humana as of January 1, that does not guarantee he/she will remain with the Plan throughout the year. Providers may discontinue participation with Humana at any time during the year. The Personnel Cabinet has contracted with Humana to utilize their Choice Care PPO network of providers. The network is utilized by groups other than KEHP. **Neither KEHP, the Personnel Cabinet, nor the Department of Employee Insurance is involved in contract issues between providers and Humana.**

Deductible

The deductible is the initial amount of medical or hospital expenses you must pay before Humana or Express Scripts start paying benefits.

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

- No single family member has to pay more than the single deductible;
- No single family member can contribute more than the single deductible amount toward the family deductible maximum;

- Of the family maximum deductible, the single deductible amount can be met by a family member and the remaining deductible can be met by a combination of additional family members;
- All family members' services can be combined and applied to meet the family deductible.

Coordination of Benefits

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

- If your spouse is covered by another health insurance plan, his/her plan is always the primary plan. Your plan through KEHP will pay as secondary.

- If your dependent children are covered by another health insurance plan, the primary plan for your dependent children is the parent's plan whose birthday occurs first in the calendar year. If both parents have the same birthday, the plan that has been in force for the longest period of time is the primary plan.

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

Note:

Humana will require you to provide information on an annual basis regarding coordination of benefits. **The information must be provided BEFORE claims are paid.**

KEHP 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. 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.

HIPAA Special Enrollment Provision Loss of Other Coverage.

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 35 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 35.

PRESCRIPTION DRUG BENEFITS

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

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

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

Generic drugs

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

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

Generics are:

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

Effective – generics are just as strong and deliver the same medical benefits as the brand name drugs.

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

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

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

Maintenance Drug Mail Order and 90-Day Retail Programs

You may receive a 90-day supply of maintenance drugs through Express Scripts mail order or through participating local retail pharmacies.

Purchasing the 90-day supply of maintenance drugs allows you to pay for a three-month supply for a two-month co-pay or co-insurance. Express Scripts utilizes First Data Bank to determine which drugs are considered maintenance drugs. First Data Bank makes this determination based on the drug company's recommended dosage and the Food and Drug Administration.

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

The maintenance drug mail order and 90-day retail programs are available two ways:

- through Express Scripts mail order program, which delivers your prescription straight to your door or
- at participating retail pharmacies by simply going to the retail pharmacy to pick up your prescription.

For a listing of the local retail pharmacies participating in the mail order program, refer to KEHP web site or contact Express Scripts.

Home Delivery Education (HDE) Overview

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

- Personalized Messaging - Letter content may include the name of targeted drugs you have filled at retail and any potential annual savings.

- Express Scripts will call your doctor for you to get a new prescription for the mail order benefit. You are given the option to get started with the mail order benefits either:
  - Online by visiting www.express-scripts/startnow, or
  - Calling the provided dedicated customer service phone number to speak with a Patient Care Advocate

- Self service – you will be instructed how to send a prescription to Express Scripts Home Delivery and you will be provided with a mailer to use to submit your prescription. You may also take that prescription to your local participating pharmacy to receive the benefit.

- Automated Outbound Call – you may receive an automated outbound call with an option to transfer to a Patient Care Advocate

offering assistance in getting started with the mail order benefit.

Quantity Level Limits

Quantities of some medications may be limited based on recommendations by the Food and Drug Administration (FDA) and the manufacturer. Limits are in place to ensure safe and effective drug use and to guard against overuse of such drugs. Drugs subject to the QLL are indicated on the Formulary Listing. If there is a medical reason that you would need above the QLL, your doctor can call Express Scripts for a prior authorization.

CuraScript Specialty Pharmacy

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

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

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

You may contact CuraScript toll-free at 866 413-4135 (Monday – Friday 8:00 a.m. – 9:00 p.m., Eastern Standard Time, and Saturday 9:00 a.m. – 1:00 p.m., Eastern Standard Time). A Patient Care Coordinator will contact your physician and work with you to schedule a delivery time for the medication.

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

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

Prior Authorizations

KEHP requires prior authorization for specific medications. The purpose of prior authorization is to promote clinically appropriate, cost-effective drug therapy using objective clinical criteria. If you take a new prescription

to the pharmacy and the pharmacist says it requires prior authorization, ask your physician to call Express Scripts' Prior Authorization line at 800 241-1390. Your physician must call for the prior authorization.

Step Therapy

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

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

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

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

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

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

Note

The formulary remains the same throughout the year unless:

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

Inherited Metabolic Diseases

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

Frequently Asked Questions regarding prescription drug benefits

Why is it necessary to have a formulary?

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

How will members know what drugs are on the formulary?

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

Where can I locate a copy of the formulary?

A formulary can be located on KEHP's web site at www.kehp.ky.gov.

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

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

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

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

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

KEHP has an appeals process for any denial of prescription drugs. Refer to pages 59-52 for additional information regarding appeals.

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

With Step Therapy, second step drugs are covered if:

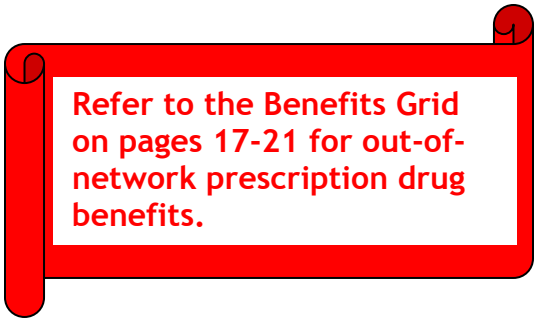
- you have recently tried first step drugs that are covered in the Step Therapy program, or
- your doctor decides you need a second step drug for medical reasons.

PRESCRIPTION DRUG BENEFITS (CONTINUED)

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

Are generic medications safe and effective?

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



INFORMED CARE MANAGEMENT

INFORMED CARE MANAGEMENT: A PROGRAM FOR PEOPLE WITH CHRONIC CONDITIONS

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

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

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

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

- Review your health information with you;
- Ensure you are receiving all recommended services for your condition;
- Discuss targets and goals related to your conditions;
- Prepare a plan to help you meet your health goals;
- Suggest questions to ask your doctor;
- Inform you about warning signs and symptoms and what you should do if they occur;
- Identify ways for you to stay healthy; and
- Send you follow up letters that summarize your engagement with the nurse and helpful educational materials.

As a member of ICM, your health information is constantly being monitored by your nurse and ActiveHealth. Your Nurse Care Manager will ask you questions about your diet, exercise, allergies and over-the-counter medications

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

ICM conditions include, but are not limited to:

- Asthma – adult and pediatric
- Chronic Obstructive Pulmonary Disease (COPD)
- Diabetes – adult and pediatric
- Breast Cancer
- Congestive Heart Failure
- Coronary Artery Disease
- Hypertension
- Back Pain
- Cancer

For a complete list of the ICM conditions, call 877 KEHPWELL (877 534-7935.

INFORMED CARE MANAGEMENT (CONTINUED)

Why Weight Kentucky

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

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

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

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

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

For more information on the Why Weight Kentucky program, or to sign up, call 877 KEHPWELL (877 534-7935)

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

Maternity Program

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

Personalized Care Plan

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

INFORMED CARE MANAGEMENT (CONTINUED)

Support and Education

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

The Nurse Care Manager will focus on:

- The importance of regular prenatal care
- Education regarding vaccinations, genetic testing and first trimester screening
- Reviewing your medications and educating you regarding medication safety during pregnancy
- Promoting a healthy pregnancy and lifestyle
- Discussing how any previous or current medical conditions may affect your current pregnancy
- Reviewing the nutritional needs of a pregnant woman
- Educating you regarding the important warning signs/symptoms related to pregnancy complications, including preterm labor and pre-eclampsia
- Reinforcing the importance of seeking prompt medical attention if warning signs/symptoms occur
- Screening you for and educating you about depression and pregnancy
- Providing you with literature, including the Baby and Me book and literature on breastfeeding and nutrition.

Helping you talk to your doctor(s)

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

For more information on the Maternity Program, you may contact ActiveHealth at 877 KEHPWELL (877 534-7935).

KEHP WELLNESS PROGRAMS

Smoking Cessation Program

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

Who is eligible?

Any smoker who is 18 years old or older and is covered (enrolled) through KEHP is eligible to participate in the program.

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

What do I have to do?

Enroll in a Cooper Clayton program or in the Kentucky Tobacco Quit Line.

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

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

How much of the NRT product will I receive?

Eligible participants who continue participating in an approved smoking cessation program *will receive 12 weeks of over-the-counter NRT products each calendar year*. The NRT products are not eligible for the mail order benefit.

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

How much will it cost me?

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

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

If you have questions regarding eligibility and benefits with this program, you may contact the Department of Employee Insurance KEHP Wellness Hotline at 877 KEHPWELL (877 534-7935). Information is also available on our web site at www.kehp.ky.gov.

To find out where a Cooper Clayton Program is offered in your area you may contact the Department of Employee Insurance KEHP Wellness Hotline at 877 KEHPWELL (877 534-7935).

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

Humana Health Assessment (HHA)

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

Take the first step

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

The information you provide for your HHA generates a personalized report that is strictly confidential. The Commonwealth, nor your employer, will see your individual results. Humana will use this report, along with your medical claims history, to determine if you would benefit from an Informed Care Management Program. Humana will provide KEHP with cumulative summary data from the completed HHAs with no identifying personal information.

Based on your responses to the questions, the HHA can evaluate your risk for medical conditions. It will also provide you with information to discuss with your physician, as well as web site links to other resources that provide further assistance.

The HHA takes about 15 minutes to complete and the benefits can last a lifetime. This is an opportunity to gauge your health status and learn how to begin your Journey to Wellness.

How to take your Humana Health Assessment

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

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

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

Instructions for completing the HHA by phone (Humana insured only)

To take the Humana Health Assessment by phone:

- Have your member ID and date of birth available.
- Dial 1-866-444-6096 and answer the questions.
- Your results will be mailed directly to you.

Instructions for waivers without the Humana HRA (health departments and certain quasi governmental agencies)

Here is how easy it is for you to take the HHA if you are not enrolled in either Humana health insurance or the Humana Health Reimbursement Account:

- Go to www.myHumana.com/hha
- Click on the *Take the Assessment* link
- Select Commonwealth of Kentucky from the drop-down menu and enter your information
- Review Humana's disclaimer and agreement
- Start the assessment!

Who can participate in the HHA?

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

Do I have to participate?

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

Health Coaching Program

After completing the HHA, you qualify for a free personal Health Coach who will help you change your lifestyle and accomplish your health goals. The following programs are offered to you as a benefit of KEHP. Sign up today and let the professionals help you achieve your health goals.

Enroll in any or all of the Health Coaching programs to receive a personalized action plan and assistance from a phone-based health coach.

What is Health Coaching?

As part of the wellness program for Humana members, Health Coaching offers telephone consultations with a certified health coach on the following topics:

- **Weight management** – eight-week program includes bimonthly calls from your coach and personalized meal, exercise and behavior modification strategies.

- **Nutrition** – six-week program teaches you how to make smart, satisfying food choices, and how to prepare tasty low-fat food choices.

- **Stress Management** – helps you deal with stress resulting from work, school, relationships and finances.

- **Tobacco Cessation** – will help you design a personal plan for decreasing your dependency, managing withdrawal and dealing with cravings.

- **Back Care** – provides guidance from your coach on how to manage your back pain through flexibility, exercise, weight loss and alternative medicine.

For each program that you enroll in, you will receive five outbound calls from your Health Coach; however you will be provided contact information for your Health Coach and will have unlimited access to the Health Coach for twelve months.

How do you sign up for Health Coaching?

It's easy! To register online:

- Go to www.myhumana.com
- Log on to MyHumana or register, if you have not already done so
- Under the "Health & Wellness" tab, chose "Wellness"
- Click on the "Health Coaching" link

Once you click on the Health Coaching link, you will be taken to the Humana site and will be asked to enter your health insurance ID number. Once you are on the Health Coaching site, you can sign up for any or all of the programs. You will be asked to complete a questionnaire that will enable them to develop a personalized action plan that will be used by you and your Health Coach to develop goals and action items for you. Once you complete the questionnaire and state that you want a Health Coach, someone will call you within 48 hours.

If you do not have access to the Internet, register by phone and receive your health coaching information packet and enrollment application in the mail:

- You will need your Humana member ID number and date of birth
- Call 1-866-671-4536
- Choose a program.

Preventive Services

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

Well child care (routine)

Well child care benefits include the following:

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

KEHP WELLNESS PROGRAMS (CONTINUED)

Adult well care (routine)

Coverage includes:

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

HumanaFirst® Nurse Advice Line

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

HumanaFirst can be of assistance when, for example:

- You are worried about a family member's illness.
- You have fallen and you don't know if you need to go to the hospital.
- Your child has a fever in the middle of the night.

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

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

KEHP WELLNESS PROGRAMS (CONTINUED)

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

Virgin HealthMiles Program

The Virgin HealthMiles Program is available to all KEHP employees and retirees, KEHP dependents over 18, and to waivers, friends, and family members. The Virgin HealthMiles program rewards participants for making healthy choices- with CASH!

Walk, stroll, jog, pedal…just move, and the HealthMiles program does the rest. You will use a pedometer to track your activity and then you can view your progress at your own personal webpage.

For more information on the Virgin HealthMiles program call 877 KEHPWELL (877 534-7935)

To enroll, check out the different reward levels and pricing or to sign up please visit the appropriate webpage listed below based on your KEHP status:

Employees:
www.virginhealthmiles/kehpemployees

Dependents:
www.virginhealthmiles/kehpdependents

Friends and Family (waivers):
www.virginhealthmiles/kehpfriends

VIRGIN AD

FLEXIBLE BENEFITS
FSA & HRA

KEHP offers two Flexible Spending Accounts (FSAs) that you should consider participating in as part of your Cafeteria plan benefits. One FSA is the **Healthcare FSA**, and the other is a **Dependent Care FSA**.

Both FSAs are tax-free accounts that allow you to pay for certain healthcare or dependent care expenses with pre-tax money. You decide how much money to contribute into each account through payroll deductions. This results in you paying less in income and Social Security taxes!

Who is eligible to participate?

You are eligible to enroll in a Healthcare and/or a Dependent Care FSA if:

- You are an active employee of a state agency, school board, or certain quasi agency who is eligible for state-sponsored health insurance coverage. If you are with a quasi agency, you must contact your Insurance Coordinator for participation details.

You are <u>not</u> eligible to enroll in a Healthcare and/or a Dependent Care FSA if:

- You are a retiree;
- You are employed by a non-participating agency; or
- You (or your spouse) have a Health Savings Account (HSA).

When will my coverage become effective?

If you enroll during Open Enrollment you will have coverage effective January 1, 2010. You may enroll online or by completing an Enrollment Application within the timeframe as specified in this Handbook.

If you are a new employee, coverage begins on the first day of the second month following your date of hire. You can enroll online or by completing an Enrollment Application within 30 days from your date of hire.

HEALTHCARE FLEXIBLE SPENDING ACCOUNT (HC FSA)

A Healthcare Flexible Spending Account (HC FSA) is an account available for you to use to pay for certain healthcare expenses such as:

- Copayments and coinsurance
- Deductibles
- Covered over-the-counter expenses
- Dental fees
- Orthodontic treatment
- Vision exams and eyeglasses
- Wheelchairs
- Saline Solution

This is not a complete listing. You can see the complete listing at www.kehp.ky.gov.

You decide how much to contribute into a Healthcare FSA on a calendar year basis, and you may contribute up to a maximum of $5000 a year available

for you and your dependents who reside in your household. Be careful how you estimate your expenses – any money left in your FSA account at the end of the year, will be forfeited. You must use-it, or you will lose-it! Review the chart below to see how a Healthcare FSA can save you money!

Example: Laura
Last year, Laura made $28,000 and put $1,500 in her healthcare FSA. The example below shows how much she saved by using the pre-tax money for qualified health expenses. Without an FSA, she would have paid for these expenses from her take-home pay, which she paid taxes on. ***She saved $340****.*

	No FSA	With FSA
Annual Taxable Income	$28,000	$28,000
Pre-tax money deposited into FSA through payroll deduction.	0	$1,500
Remaining taxable income	$28,000	$26,500
Minus federal and Social Security taxes	$5,945	$5,605
Remaining take-home pay	$22,055	$20,895
Minus the take home pay spent on qualified expenses	$1,500	0
Remaining take home pay	$20,555	**$20,895**
Savings	**0**	**$340**

This example is intended to demonstrate a typical tax savings based on 13.58% federal and 7.65% FICA taxes. Actual savings will vary based on your individual tax situation. Consult a tax professional for more information on tax implications of an FSA.

How will I be reimbursed for my Healthcare FSA expenses?

It's easy! You will receive the free Humana*Access*℠ VISA® debit card, and your funds will be automatically deducted from your account. Refer to page 48 for additional information on the Humana*Access*℠ VISA® debit card You can use the debit card anywhere that VISA is accepted. Because of IRS rules, Humana may contact you to verify that your expense is a qualified expense.

When you make your purchase, you simply swipe your card at your provider's office or pharmacy to pay for your expense. Remember to save your receipt!! Or, if you prefer, you can pay for your expenses up-front and then mail or fax a copy of your claim to:

FLEXIBLE BENEFITS
FSA & HRA

Humana Spending Account
Administration Unit
P.O. Box 14167
Lexington, KY 40512-4167
800-604-6228
800-905-1851 Fax

Why do I have to save my receipts?

You must save your receipts because the IRS requires that 100% of all claims be verified as an eligible expense. Humana, our third-party administrator will try to verify that the service you received is eligible for reimbursement. If Humana cannot verify that the service is eligible, you will be required to provide documentation to them to substantiate your claim.

If you have your health insurance coverage with KEHP, then most of your healthcare FSA claims will automatically be substantiated by Humana and you will not be required to provide any documentation. If you waive your health insurance with KEHP then you will be required to substantiate all of your claims. As a waiver, Humana will not have access to your health insurance claims and therefore will not be able automatically substantiate them.

Humana will attempt to substantiate claims for 30 days. If after 30 days the expense cannot be verified, you will be sent a letter requesting that you submit an itemized statement or an Explanation of Benefits (EOB) from your primary health plan, if applicable. If the substantiation is not received within 30 more days, for a total of 60 days from the date of service or Humana Access Card swipe, then claims processing will be suspended. This suspension will include the use of the HAC as well as reimbursements for traditional paper claims.

Please Note: All dental and vision claims will require substantiation because Humana does not process dental and vision claims for KEHP.

How long do I have to receive reimbursement for my claims?

All claims incurred during your coverage period must be submitted for reimbursement by March 31st of the following year. This is referred to as the 'run-out period'. This applies if you are covered the full Plan Year (January 1 – December 31) or if your coverage terminates during the year.

Examples:

If you have coverage from January 1, 2010 through July 31, 2010, you have until March 31, 2011 to submit your claims for reimbursement, provided the claims were rendered during your coverage period of 1/1 through 7/31.

If you have coverage from January 1, 2010 through December 31, 2010, you have until March 31, 2011 to submit your claims for reimbursement, provided the claims were rendered during your coverage period of 1/1 through 12/31.

- No claims will be reimbursed if the date of service is rendered after your termination date, or if the claims are submitted after your run-out period.
- No claims will be reimbursed if you swipe your Humana*Access*℠ VISA® debit card after your termination date or after the run-out period.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (DC FSA)

A dependent care FSA allows you to pay for dependent care expenses such as a day care or after-school program for dependents up to age 13, or an adult day care – on a pretax basis! The maximum that you can contribute per year is based on your tax-filing status as listed below:

Married, filing a joint return	$5,000
Head-of-Household	$5,000
Married, filing separate returns	$2,500

Make sure to set aside only as much as you will use – with an FSA, you can use the money only for eligible expenses paid for during the current plan year. **Remember: Use-it or lose-it!**

How will I be reimbursed for my Dependent Care FSA expenses?

You must submit a statement from your daycare to Humana, which reflects the amount charged for your services. Humana will issue you a check, or directly deposit your reimbursement into your checking account. You must submit your statement along with a completed FSA Reimbursement Form and mail or fax your claims to:

Humana Spending Account
Administration
P.O. Box 14167
Lexington KY 40512-4167
FAX 800-905-1851

HEALTH REIMBURSEMENT ACCOUNTS (HRA) – WAIVING HEALTH INSURANCE COVERAGE

If you choose to waive your health insurance coverage, you may be eligible to receive an HRA. An HRA is a federally qualified expense account that consists of funds that are set aside by **employers** to reimburse employees for qualified medical expenses such as deductibles, co-pays, vision services, and dental services. (For a complete listing of covered services visit our web site at www.kehp.ky.gov).

Under KEHP, if you waive health insurance coverage your employer will contribute $175 per month or $2100 per year to an HRA provided you are an active employee. Employees hired with an effective date later than January 1, will receive $175 for each month in

which they are eligible for health insurance. For example, if you are hired on March 1, you would be eligible for the employer contribution beginning May 1, and would receive $175 for eight months.

Unlike the FSA, any balance remaining in your HRA at the end of the calendar year, will 'roll over' to the next calendar year, as long as you continue to waive your health insurance coverage.

Note: Employees who are 65 years old or older who waive health insurance benefits will receive a health insurance waiver **only**. After enrollment in the waiver plan, the employee must provide proof of other continuous primary health coverage, not including Medicare or a Medicare supplemental plan. Once proof of other coverage is provided, KEHP will re-evaluate the employee's eligibility and determine if they are eligible to receive the HRA funds.

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

Who is eligible to participate?

You are eligible to waive health insurance and enroll in the HRA if you are an active employee of a state agency, school board, or certain quasi agency who is eligible for state-sponsored health insurance coverage.

Who is NOT eligible?

- If you (or your spouse) have a Health Savings account (HSA), you are not allowed to have an HRA. If you have both, you will be in violation of federal tax law.
- If you are a member of an agency who chose NOT to participate in KEHP HRA.

Note:

If you elect health insurance coverage now, and later experience a Qualifying Event to drop your health insurance coverage, you will NOT receive any HRA funds. You will only be waiving your health insurance, but no HRA funds will be deposited into an HRA.

HUMANA*ACCESS* VISA card

You will receive a HumanaAccess card if:

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

Activate it

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

Pay for other healthcare services

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

Use your Humana*Access* card to pay for any eligible healthcare expenses, such as:

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

Note: You cannot use your HumanaAccess card for Dependent Care FSA expenses, which are explained on the previous page.

Manage your balance

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

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

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

MEDICAL CLAIMS APPEALS

Note: The appeals procedures described below are only for medical and prescription drug concerns. Refer to page 72 if you would like to file a grievance regarding eligibility or enrollment.

Appeals

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

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

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

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

Who performs the appeal?

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

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

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

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

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

MEDICAL CLAIMS APPEALS (CONTINUED)

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

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

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

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

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

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

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

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

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

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

covered person or the unborn child in serious jeopardy;
- Serious impairment of bodily functions; or
- Serious dysfunction of a bodily organ or part.

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

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

How to file an External Appeal- Adverse Determination

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

Adverse Determinations - If the member is not satisfied with the decision of the internal appeal regarding an adverse determination, the member may request an external appeal. The external appeal will be handled by an independent review entity (IRE) that is certified by the Kentucky 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 60 days after receipt of the internal appeal decision letter. The member must have completed the internal appeal process, or the Third Party Administrator must have failed to make a timely determination or notification. In addition, the member must have been eligible and enrolled on the date of service and eligible to receive covered benefits under the health benefit plan on the date the service was requested and the treatment or service must cost the member at least $100 if the member did not have insurance.

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

The request for an external review must be submitted to the address as listed on pages 49-52. The request must include consent for the Third Party Administrator to release all necessary medical records to the IRE. The IRE must render a decision within 21 calendar days of receipt of the information required from the Third Party Administrator. An extension is available to the IRE if both the member and the Third Party Administrator agree in advance.

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

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

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

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

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

Coverage Denials

If the member is not satisfied with the decision of the internal appeal of a coverage denial, the member may request a review by the Kentucky 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.

Administrative Appeal for prescription drug changes

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

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

NOTICE OF CREDITABLE COVERAGE

2010 Plan Year
Important Notice from Kentucky Employees' Health Plan About
Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Kentucky Employees' Health Plan and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The Kentucky Employees' Health Plan has determined that the prescription drug coverage offered by the Kentucky Employee's Health Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15th through December 31st. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

NOTICE OF CREDITABLE COVERAGE

If you decide to join a Medicare drug plan, your current Kentucky Employees' Health Plan coverage will be affected. For additional information about your Kentucky Employees' Health Plan Prescription Drug coverage please see the 2010 Prescription Drug Summary Plan Descriptions. Please also see pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current Kentucky Employees' Health Plan coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with the Kentucky Employees' Health Plan and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Use the contact information listed below for further information the Personnel Cabinet, Department of Employee Insurance, 501 High Street, 2nd Floor, Frankfort, Kentucky 40601. 502-564-0358 or toll free at 888 581-8834. You may also visit the Department of Employee Insurance website at www.kehp.ky.gov and the Kentucky Employees' Health Plan 2010 Prescription Drug Summary Plan Descriptions.

Note:

You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Kentucky

NOTICE OF CREDITABLE COVERAGE

Employees' Health Plan changes. You also may request a copy of this notice at any time.

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:
• Visit www.medicare.gov
• Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
• Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Contact Information:

Date: January 1, 2010
Name of Entity/Sender: Kentucky Employees' Health Plan
Contact--Position/Office: Department of Employee Insurance
Address: 501 High Street, 2nd Floor, Frankfort, Kentucky 40601
Phone Number: 502-564-0358 or toll free at 888 581-8834

ELIGIBILITY AND ENROLLMENT

Eligible Participants

1. Full-time employees

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

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

2. Retirees

- under the age of 65; or
- retirees age 65 or older and not eligible for Medicare; or
- retirees eligible for Medicare and actively employed with a participating agency

and who draw a monthly retirement check from any of the following retirement systems are eligible to participate:

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

3. COBRA Qualified Beneficiaries

Eligible COBRA participants who were previously covered under KEHP.

4. Dependents

The following dependents are eligible for participation under KEHP:

- An employee's spouse under an existing legal marriage
- A member's unmarried (never been married) dependent child, step child or court ordered child.

KEHP dependent child eligibility rules

Pursuant to KRS 304.17A.256, KEHP rules for Unmarried Dependent Children. (For purposes of Health Plan eligibility):

- Unmarried;(never been married)
- Has a specific, family-type relationship to the planholder (an unmarried dependent child is a member's blood child, stepchild, adopted/placed child, foster child or grandchild, if member has legal guardianship or custody papers).
- Planholder is primarily responsible for dependents maintenance and support; and
- Is under age 25.

ELIGIBILITY AND ENROLLMENT

NOTE: Dependent coverage is paid on a pre-tax basis up to the end of the year in which said child turns 23. The DEI automatically drops the dependent child as of December 31 of the year in which the dependent child turns 23. If the employee wishes to continue to cover that dependent child, he/she must enroll them during Open Enrollment, if eligible. If the dependent child does not qualify for pre-tax status as a Qualifying Child or Relative he/she will be enrolled as a post-tax dependent. The employee will have to re-enroll the dependent each year until they turn 25, if they continue to qualify as a dependent.

Upon reaching age 25, the dependent child will become ineligible and be terminated at the end of the month in which the birthday occurs.

Note: 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.

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 KEHP eligibility rules.

Temporary absences, such as for school, are permitted.

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

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

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

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

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

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

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

If, during Open Enrollment, you wish to enroll a disabled dependent that is past the limiting age specified under the eligibility rules, you must show proof that the disabled dependent has experienced a loss of coverage. The request to add the disabled dependent must be made within 35 calendar days of the Qualifying Event.

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 KEHP's Section 125 cafeteria plan.

The WFTRA of 2004 developed a new definition for "qualified child" and "qualified relative." An employee will NOT be able to pay dependent premiums on a pre-tax basis if the employee's dependent(s) CANNOT MEET ONE of these definitions (qualifying child or qualifying relative).

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

Pursuant to I.R.C. § 152, the new definitions are as follows:
A "qualifying child" (QC) is a child who:

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

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

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

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

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

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

ELIGIBILITY AND ENROLLMENT (CONTINUED)

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

IMPORTANT: I.R.C. § 152 does **not** change KEHP's eligibility rules. It does **not** create any new category of eligible dependents, or make people who were previously ineligible for coverage now eligible. A dependent shall meet KEHP's eligibility rules before an employee may add the dependent to the Plan. **Adding a dependent to the Plan who does not meet KEHP eligibility rules may be considered insurance fraud.**

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.

Age limits	Eligibility Qualifier 1	Eligibility Qualifier 2	Tax treatment
0- to 19th birthday	Must meet KEHP dependent definition and Q.C. definition (does not require full-time student status)	Must meet KEHP dependent definition and Q.R. definition	Pre-tax
19- to end of 23rd year	Must meet KEHP dependent definition and Q.C. definition (requires full-time student status)	Must meet KEHP dependent definition and Q.R. definition	Pre-tax
Up to 25th birthday	Cannot meet Q.C. definition due to age.	Must meet KEHP dependent definition and Q.R. definition	Post-tax, but may be eligible for Pre-tax

ELIGIBILITY AND ENROLLMENT (CONTINUED)

Eligibility Limitations

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

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

Levels of Coverage

Single – Covers the employee/retiree only
Parent Plus – Covers the employee/retiree and one or more children, but does not cover the spouse
Couple – Covers an employee/retiree and his/her legal spouse
Family – Covers an employee/retiree, his/her legal spouse and one or more children

Waiving Coverage

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

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

FAMILY CROSS-REFERENCE PAYMENT OPTION

What is the Family Cross-Reference Payment Option?

A Family Cross-Reference payment option is a legislatively mandated payment option available only for two eligible employees who are: 1) legally married and 2) have at least 1 eligible dependent. When choosing this option the dual planholders are required to elect the same plan coverage, complete all other required information when enrolling and have both planholders authorize or sign the enrollment election form.

Am I eligible to elect the family Cross-Reference Payment Option?

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

- the members must be legally married (husband and wife) with at least one dependent;
- the members must be eligible employees or retirees* of a group participating in KEHP;
- the members must elect the same coverage**; and
- both members must sign the appropriate documentation within the enrollment deadline and file with their agency's Insurance Coordinator. Both Insurance Coordinators must sign the form. If during Open Enrollment you enroll online, you will be required to enter both members' passwords via the web.

If you do not meet **all** of the requirements listed above, you are not eligible for the cross-reference payment option.

Note: If a Post-tax child is added/covered by the cross reference payment option, both active employee plan holders will be defaulted to Post-tax status.

* Members of the Judicial and Legislators Retirement Plans are not eligible to elect the cross-reference payment option.
** The Commonwealth Maximum Choice Plan is only available for active employees. Therefore, the Commonwealth Maximum Choice Plan may not be selected by active employees who cross-reference with an eligible retiree.

How does 1) loss of employment and 2) divorce affect the Cross-reference Payment Option?

1) A Family Cross-Reference payment option is a legislatively mandated payment option for two eligible employees. Thus, the Family Cross-Reference payment option in fact has two planholders.

If either employee loses employment/coverage eligibility 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. The remaining planholder will be permitted to move from "family" coverage to either "parent plus" or

FAMILY CROSS-REFERENCE PAYMENT OPTION

"single" coverage. To make this change in level of coverage the planholder must contact their Insurance Coordinator and submit their desired level of coverage with 35 days of the qualifying event. If the desired level of coverage is not submitted the remaining planholder will be assigned "Parent Plus" coverage. This level will remain in effect until the next Open Enrollment, unless an appropriate Qualifying Event occurs.

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 loss of planholder status.

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. This creates a traditional family plan.

A Family Cross-Reference payment option requires that the two 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 a minimum of arrears in employee contributions and possibility other actions.

Other Events that End Eligibility

- Termination of employment or loss of employer paid benefit eligibility for one or both plan holders
- Event that allows employee to drop coverage for their spouse
- Event that allows employee to drop their **only** dependent child

Other considerations

If you are currently enrolled in KEHP and your spouse is hired by a participating agency, the newly hired employee must elect coverage to match the existing coverage. New groups that join KEHP during the Plan Year are eligible to begin a cross-reference payment option.

EFFECTIVE DATES

New Employees

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

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

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

Note: New employees age 65 and over are eligible to enroll in KEHP through their active employer or waive their benefits without receiving the stand alone HRA funds. If the employee provides proof of continuous primary health coverage, not including Medicare or Medicare Supplement plan, KEHP will re-evaluate the employee's eligibility for HRA funds.

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

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

Employees who fail to enroll will automatically default to a "Forced Waiver." Forced waivers will not receive HRA funds.

Open Enrollment

All elections made during Open Enrollment will be effective January 1, 2010.

TERMINATION DATES

Terminating employment

KEHP is a current pay health insurance plan. If you leave employment between the 1st and the 15th of the month, your health insurance coverage will terminate on the 15th of the same month. If you leave employment between the 16th and the end of the month, your health insurance coverage will terminate on the last day of the same month. Flexible Spending Accounts (FSAs) and Health Reimbursement Accounts (HRAs) end on the same day you terminate employment, regardless of when that occurred.

Dependents dropped during Open Enrollment

Any changes made during Open Enrollment that would terminate your plan or drop any dependents from your plan will be effective December 31, 2009. Dependents dropped during Open Enrollment are not eligible for COBRA, unless the removal is in anticipation of a Qualifying Event (make sure your Insurance Coordinator knows that the change is related to a Qualifying Event instead of an Open Enrollment change). If you experience a Qualifying Event between Open Enrollment and December 31, 2009, you will need to specify in writing that you wish your Open Enrollment elections to continue on January 1, 2010. Otherwise, any new elections made due to your Qualifying Event will roll over on January 1, 2010.

Termination for non-payment of premiums

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

QUALIFYING EVENTS - (for Health Insurance only)

KEHP benefits are provided through a Cafeteria Plan. This allows you to pay for your health insurance premiums with pre-tax monies, which is a savings for you. Cafeteria Plans are administered according to federal laws and regulations. Those regulations state that if your health insurance is offered through a Cafeteria Plan, you cannot change your Open Enrollment choices unless you experience an appropriate Qualifying Event. Permitted election changes (commonly known as qualifying events are set forth in Treas. Reg. 1.125-4) The Department of Employee Insurance cannot modify the regulations related to Qualifying Events. The effective date for changes to your plan must be consistent with the Qualifying Event date. The change cannot take place before the event occurs.

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

Effective Dates To add dependents:

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

Exceptions:

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

QUALIFYING EVENTS (CONTINUED)

If you are adding the newborn plus other dependents, the time limit for enrollment is 35 days.

Adoption/Placement for adoption – children added due to this Qualifying Event are effective on the date of adoption or placement for adoption if application is completed within the specified timeframe. If you are adding the newly adopted/placed child only, the time limit is 60 days. If you are adding the newly adopted child plus dependents, the time limit is 35 days.

To drop dependents:

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

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

Exceptions:

Loss of eligibility or dependent status such as divorce, a child's marriage, a child's establishment of a separate primary residence and a child turning 25 – dependents dropped due to these Qualifying Events are terminated effective on the last day of the month in which the event occurs regardless of signature date.

Deadlines

Employees have no later than 35 calendar days after the event occurs to sign and date the appropriate form requesting a change.

Exceptions:

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

If the employee is requesting to add additional dependents (other than the newborn or the newly adopted/placed child), he/she will have 35 days (not 60) after the event to make the request, sign and date the application or Dependent Add Form.

QUALIFYING EVENTS (CONTINUED)

Special processing guidelines

- The effective dates for Qualifying Events are based on the **date the event occurred**.

- In certain cases, the Department of Employee Insurance will accept a Notification Date. The notification date is the date the employee is notified by another source that an event affecting his/her eligibility for a different coverage has occurred. The Department of Employee Insurance will accept a notification date (in lieu of the event date) only in the following cases:

    - Eligibility for governmental programs (Medicare, Medicaid, Loss of KCHIP)
    - CHAMPVA
    - TRICARE

- Spouse/Retiree Has Different Open Enrollment Period: The following processing rules apply to this Qualifying Event:

    - The Qualifying Event date is the last day of the spouse/retiree's Open Enrollment period.
    - The application or form can be signed prior to the event date.
    - The effective date of the selected coverage will correspond with the effective date of the spouse/retiree's Open Enrollment elections.

Supporting documentation

The Qualifying Events listed below require supporting documentation to be submitted with the appropriate Dependent Add Form or Dependent Drop Form. If you are having difficulty getting the required supporting documentation, **DO NOT** delay in completing the required form. You only have 35 calendar days to sign and date the form. Complete, sign, date and submit the form within the deadline and submit the supporting documentation at a later date, if necessary. Not having the needed supporting documentation is not a reason for an extension of the 35 calendar day deadline.

Divorce/Legal Separation/Annulment

- If dropping spouse from the plan: Filed decree, legal separation, or annulment papers signed by a judge and date-stamped "filed."

- If enrolling due to loss of other coverage: Proof that you were covered under your spouse's plan and are no longer eligible (HIPAA certificate or letter from employer on letterhead, identifying the date of insurance termination and the persons who were covered by the policy).

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

QUALIFYING EVENTS (CONTINUED)

Adoption or placement for adoption

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

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

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

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

- Initial eligibility letter from the Medicare/Medicaid Office.

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

Gaining KCHIP is NOT a Qualifying Event to drop coverage.

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

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

Gaining other group health insurance coverage

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

QUALIFYING EVENTS (CONTINUED)

Different Open Enrollment

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

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

- Can be added to your coverage by selecting the Qualifying Event of Legal Guardianship, Administrative Order or Court Order on the Dependent Add Form.

- The effective date of coverage is the first day of the first month after the employee's signature date on the Dependent Add Form and must be consistent with the event date. The effective date cannot take place before the event date.

- The deadline to add children under this Qualifying Event is no later than 35 calendar days from the Qualifying Event. The Qualifying Event date is the date that the Legal Guardianship, Court Order or Administrative Order is filed by the court and dated by a judge.

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

All children added to an employee's health insurance coverage must meet the dependent eligibility requirements as described on pages 56-60.

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

QUALIFYING EVENTS (CONTINUED)

Important Qualifying Event facts

As soon as you are aware that you may be experiencing a Qualifying Event, please do the following:

1) Immediately obtain the appropriate form from your insurance coordinator or from the web site.

2) Immediately sign and date the form. Do not delay signing and dating the form. Applications and forms signed after the appropriate deadlines will not be accepted. If you are requesting a change to a cross-reference payment option plan, both members must sign and date the form within the deadline. Please see www.kyhp.ky.gov.

3) Supporting documentation must be submitted when requested or required. The inability to obtain the required supporting documentation is not a reason for an extension.

Effective Dates and Deadlines

Employees have no later than 35 days from the date of the event to sign the appropriate form requesting a change. This form should be submitted to your Insurance Coordinator.

HOW DO I KNOW WHICH FORM TO USE?

You should use the Enrollment Application for the following events:

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

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

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

ELIGIBILITY AND ENROLLMENT GRIEVANCES

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

Grievances must be filed in writing to:

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

A grievance must include ALL of the following items:

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

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

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

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

NOTE: This grievance committee only reviews grievances for enrollment and eligibility. Any appeals for claims must be submitted as outlined on pages 49-52.

COBRA

Continuation Coverage Rights Under COBRA

Introduction.

You are receiving this notice because you have recently become covered under a group health plan (the "Kentucky Employees' Health Plan"). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;

- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

Qualified beneficiaries also include a child born to or placed for adoption with the covered employee who satisfies the plan eligibility requirements and becomes covered under the Plan during the period of COBRA coverage.

For Retirees.

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Kentucky Employees' Health Plan, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after Ceridian has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the sponsoring employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify Ceridian of the qualifying event.

You Must Give Notice of Some Qualifying Events.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child) causing a loss of coverage, you must notify Ceridian in writing within 60 days after the later of the date the qualifying event occurs or the date that you would lose benefits due to a qualifying event. The employee or family member can provide notice on behalf of themselves as well as other

family members affected by the qualifying event. The written notice of the qualifying event should be sent to Ceridian, at the address provided in this notice, and should include all of the following:

- Date (month/day/year)
- Spouse/Dependent's Name
- Social Security Number/ID#
- Spouse/Dependent's Address
- Spouse/Dependent's Telephone # Gender
- Date of Birth (month/day/year)
- Relationship to Employee
- Employer's Name Employee's
- Name
- Employee's SSN/ID# \
- Reason for Loss of Coverage
- Loss of Coverage (month/day/year)

If you need help acting on behalf of an incompetent beneficiary, please contact Ceridian for assistance.

Ceridian COBRA Services
3201 34th Street South, St. Petersburg, FL 337711-3828
800 877-7994.

How is COBRA Coverage Provided?

Once Ceridian receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. You will not have to show that you are insurable to choose continuation coverage. However, you will have to pay the group rate premium for your continuation coverage plus a 2% administration fee, if applicable.

How long does COBRA coverage last?

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of

the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage.

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify Ceridian in writing in a timely fashion, you and your entire family may be entitled to receive an additional 11 months of COBRA continuation coverage for a total maximum of 29 months. The disability would have 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 the written determination of disability from the Social Security Administration to Ceridian within 60 days of the latest of the date of the disability determination by the Social Security Administration, the date of the qualifying event or the benefit termination date; and prior to the end of the 18-month COBRA continuation period. You will be required to pay up to 150% of the group rate during the 11-month extension.

Second qualifying event extension of 18-month period of continuation coverage.

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to Ceridian. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions.

Questions concerning your Plan should be addressed to the Plan Administrator of the sponsoring employer identified at the top of the first page of this document. Questions concerning your COBRA continuation coverage rights should be addressed to Ceridian at the address listed below. For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website

at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes.

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

The American Recovery and Reinvestment Act of 2009 (ARRA)

ARRA provides "Assistance to Eligible Individuals" with a 65% reduction in the premium for COBRA healthcare continuation coverage. In short, to be an "Eligible Individual" you must be eligible for COBRA, must elect COBRA due to being involuntarily terminated between September 1, 2008-December 31, 2009, must not be Medicare eligible, and must not be eligible for coverage under any other group health plan. If you qualify for the premium reduction program under ARRA you have the opportunity to elect COBRA within 60 days from the date you receive notice. You can receive additional information at www.ceridian-benefits.com or by calling 1-866-444-3272.

Plan Contact Information:

Kentucky Employees' Health Plan
Personnel Cabinet
Department of Employee Insurance
501 High Street, Frankfort, Kentucky 40601
502-564-6534

Ceridian COBRA Services
3201 34th Street South, St. Petersburg, Florida 337711-3828
800 877-7994

TERMS YOU NEED TO KNOW

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

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

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

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

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

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

Eligible Expenses
A provider's fee which: (a) is the provider's usual charge for a given service under the covered person's plan; (b) is within the range of fees charged by providers of similar training and experience for the same or similar service or supply within the same or similar limited geographical area; and (c) does not exceed the fee schedule developed by the Third Party Administrator. The term "eligible expense" and "reasonable and customary charge" may be interchangeable.

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

TERMS YOU NEED TO KNOW (CONTINUED)

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

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

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

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

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

Participating Provider
A physician, hospital or pharmacy, etc., that signs a contract with a Third Party Administrator. The participating provider will accept the allowable charge as its charge and will not balance bill the member.

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

Qualifying Event (as defined by Treas. Reg. 1.125-4)
An event that may allow an employee/retiree to make a mid-year election change in their coverage or, in some cases, their FSA. The change must be on account of and consistent with the Qualifying Event.

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

TERMS YOU NEED TO KNOW (CONTINUED)

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

Usual, Customary and Reasonable
A provider's fee which: (a) is the provider's usual charge for a given service under the covered person's plan; (b) is within the range of fees charged by providers of similar training and experience for the same or similar service or supply within the same or similar limited geographical area; and (c) does not exceed the fee schedule developed by the Third Party Administrator.

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

IMPORTANT NOTICE REGARDING COVERAGE FOR BREAST RECONSTRUCTION SURGERY

The Women's Health and Cancer Rights Act of 1998 (WHCRA) is a federal law that provides protections to patients who choose to have breast reconstruction in connection with a mastectomy. This federal law requires insurers offering individual health insurance coverage, as well as all group health plans, which provide medical and surgical benefits with respect to a mastectomy, to provide in a case of an insured who is receiving benefits in connection with a mastectomy, coverage for:

- Reconstruction of the breast on which the mastectomy has been performed

- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

- Prostheses and physical complications for all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient. Such cover may be subject to annual deductible and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage.

- An insurer offering individual health insurance coverage or group health plans may not:

- Deny to a patient eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the individual health insurance coverage or group health plan, solely for the purpose of avoiding the requirements of the Women's Health And Cancer Rights Act of 1998; and

- Penalize or otherwise reduce or limit the reimbursement of an attending provider, or provide incentives (monetary or otherwise) to an attending provider, to induce such a provider to provide care to an individual participant or beneficiary in a manner inconsistent with the Women's Health and Cancer Rights Act of 1998.

DEPARTMENT OF EMPLOYEE INSURANCE
HIPAA PRIVACY NOTICE

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

This Notice describes the obligations of the Department 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 Healthcare operations, or for any other purposes that are permitted or required by law. The Kentucky Employees' Health Plan (KEHP) is a self-funded governmental plan and, therefore, we are required to provide this Notice of Privacy Practice to you pursuant to HIPAA. DEI is the plan sponsor.

The HIPAA Privacy Rule protects only PHI. Generally, PHI is individually identifiable health information, including demographics information, collected from you or created or received by a Healthcare provider, Healthcare 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 Healthcare to you; or 3) past, present, or future payment for provisions of Healthcare 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 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, 2010.

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 Healthcare Operations;** 4) **To Business Associates;** 5) **As Required by**

DEPARTMENT OF EMPLOYEE INSURANCE
HIPAA PRIVACY NOTICE (CONTINUED)

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

Special Situations

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

Required Disclosures

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

Other Disclosures

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

Participant Rights

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

Complaints

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

Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 35 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.

IMPORTANT INFORMATION FOR RETIREES

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

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

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

For **KCTCS Retirement** Benefits call 859 256-3100.

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

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

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

Legal Notices

As a member of the Kentucky Employees' Health Plan (KEHP), you have certain legal rights. Several of those rights are summarized below. Please read these provisions carefully so that you will understand your legal rights.

A. Initial Notice about HIPAA Special Enrollment Rights, New Dependents, and Pre-existing Condition Exclusions

A federal law called HIPAA requires that we notify you about two very important provisions in the plan. The first is your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons. Second, this notice advises you of the plan's pre-existing condition exclusion rules that may temporarily exclude coverage for certain pre-existing conditions that you or a member of your family may have.

1. **Special Enrollment Provision Loss of Other Coverage.**
   If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 35 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

2. **New Dependent by Marriage, Birth, Adoption, or Placement for Adoption.**
   If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 35 days after the marriage and within 60 days after birth, adoption, or placement for adoption.

   As required by the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) effective April 1, 2009, the Kentucky Employees' Health Plan (KEHP) will permit employees and dependents who are eligible for a Child Health Insurance Program (CHIP) but not enrolled for coverage to enroll in that coverage under two scenarios: 1) The employee's or dependent's Medicaid or CHIP coverage is terminated as a result of loss of eligibility; 2) The employee or dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP. An employee must request this special enrollment within 60 days of the loss of coverage in the first scenario, and within 60 days of when eligibility is determined in the second scenario.

3. **Pre-existing Condition Exclusion Rules**
   This plan imposes a pre-existing condition exclusion. That means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period prior. Generally, this 6-month period ends the day before your coverage becomes effective. However, if you were in

a waiting period for coverage, the 6-month period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy, domestic violence, genetic information in the absence of a diagnosis for such a condition, newborn children, or children adopted before the age of 18, if they are covered under the Plan within the required timeframes.

This exclusion may last up to 12 months from your first day of coverage or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage (HIPAA Certificates) you have. If you do not have a Certificate, but you do have prior health coverage, we will help you obtain a Certificate from your prior plan or issuer. There are also other ways you can show that you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

All questions about the preexisting condition exclusion and creditable coverage should be directed to the Department of Employee Insurance, Member Services Branch. 888 581-8834, 502 564-6534 or http://personnel.ky.gov/dei/.

B. Notice To Enrollees Concerning Tobacco Use

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.**

C. COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1986, or COBRA, provides that virtually all employers who sponsor group health plans must permit covered individuals, who lose coverage under that plan as a result of certain enumerated events, to elect to continue their coverage under the plan for a prescribed period of time on a self-pay basis. Individuals who are entitled to COBRA continuation coverage are known as Qualified Beneficiaries. **Under federal law, you must have 60 days after the date of the COBRA Qualifying Event or date you lose benefits due to a COBRA Qualifying Event to decide whether you want to elect COBRA continuation coverage under the Plan.**

The American Recovery and Reinvestment Act of 2009 (ARRA) provides "Assistance to Eligible Individuals" with a 65% reduction in the premium for COBRA health care

continuation coverage. In short, to be an "Eligible Individual" you must be eligible for COBRA, must elect COBRA due to being involuntarily terminated between September 1, 2008-December 31, 2009, must not be Medicare eligible, and must not be eligible for coverage under any other group health plan. If you qualify for the premium reduction program under ARRA you have the opportunity to elect COBRA within 60 days from the date you receive notice. You can receive additional information at www.ceridian-benefits.com or by calling 1-866-444-3272. If you have questions regarding your COBRA rights, contact your agency's Insurance Coordinator, or the Department of Employee Insurance, Member Services Branch or visit http://personnel.ky.gov/dei/.

D. The Women's Health and Cancer Rights Act of 1998 (WHCRA)

The Women's Health and Cancer Rights Act of 1998 is a federal law that provides protections to patients who choose to have breast reconstruction in connection with a mastectomy. This federal law requires insurers offering individual health insurance coverage, as well as all group health plans, which provide medical and surgical benefits with respect to a mastectomy, to provide in a case of an insured who is receiving benefits in connection with a mastectomy.

E. Mental Health Parity Act

The Mental Health Parity Act provides for parity in the application of aggregate lifetime and annual dollar limits on mental health benefits with dollar limits on medical/surgical benefits. A plan that does not impose an annual or lifetime dollar limit on medical and surgical benefits may not impose such a dollar limit on mental health benefits offered under the plan.

F. Newborns' And Mothers' Health Proection Act

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)

G. Michelle's Law

Michelle's Law, effective January 1, 2010, allows seriously ill or injured college students who are covered dependents under group health plans to continue coverage for up to one year while on medically necessary leaves of absence. More specifically, a group health plan that provides health insurance coverage in connection with a group health plan cannot terminate coverage of a "dependent child" due to a "medically necessary leave of absence."

H. Prescription Drug Information For Medicare-Eligible Plan Participants / Notice Of Creditable Coverage

This notice confirms that your existing prescription drug coverage through the Kentucky Employees'' Health Plan is, on average, as good as or better than the standard Medicare prescription drug coverage (Medicare Part D). **You may keep your existing group prescription drug coverage and choose not to enroll in a Medicare Part D Plan**. With this Notice of Creditable Coverage, you will not be penalized if you later decide to enroll in a Medicare prescription drug plan. **However, you must remember that if you drop**

your entire group coverage through the Kentucky Employees' Health Plan and do not enroll in a Medicare Part D Plan after your existing group coverage ends, you may be penalized if you later enroll in a Medicare Part D Plan. If you keep your existing group coverage, it is NOT necessary to join a Medicare prescription drug plan this year.

I. HIPAA Privacy Notice

This Notice describes the obligations of the Commonwealth of Kentucky, Personnel Cabinet, Kentucky Employees' Health Plan and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Among other things, this Notice describes how your protected health information 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. We are required to provide this Notice of Privacy Practice to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic 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 provision of health care to you; or 3) past, present, or future payment for the provision of health care to you.

Please note that the Kentucky Employees' Health Plan maintains demographic, protected health information. Any member will need to contact Humana, Inc. or Express Scripts, Inc. for information relating to payment of claims and services provided under his/her health plan. If you have any additional questions about this Notice or about our Privacy Practices, please visit http://personnel.ky.gov/dei/hipaa.htm.

Commonwealth, Personnel Cabinet Responsibilities: We are required by law to: 1) maintain the privacy of your protected health information; 2) provide you with certain rights with respect to your protected health information; 3) provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; 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 protected health information that we maintain, or as required by law.

How Commonwealth, Personnel Cabinet May Use and Disclose Your Protected Health Information: Under the law, we may use or disclose your protected health information under certain circumstance without your permission. The following categories represent the different ways that we may use and disclosure your protected health information: 1) **For Treatment**. We may use or disclose your protected health information to facilitate medical treatment or services by providers. 2) **For Payment.** We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for treatment or services your receive from health care providers, to determine benefit responsibilities under the Plan, or to coordinate coverage. 3) **For Health Care Operations**. We may use and disclose your protected health care information for other Plan operations. 4) **To Business Associates**. We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. An example would be this Plan's Third Party Administrator Humana. 5) **As Required by Law.** We will disclose your protected health information when required to do so by federal, state or local law. 6) **To Avert a Serious Threat to**

Health or Safety. We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. 7) **To Plan Sponsors.** For the purpose of administering this Plan, we may disclose to certain employees of the Commonwealth, Personnel Cabinet protected health information.

Special Situations: In addition to the above, the following categories represent other possible ways we may use and disclose your protected health information: 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: The following represents disclosures of your protected health information we are required to make: 1) Government audits; and 2) disclosures to the participant (you).

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 protected health information: 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 the Plan or with the Office of Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan please visit http://personnel.ky.gov/dei/hipaacontact.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 Rights or with this Plan.

PHONE NUMBERS AND WEB SITES

Personnel Cabinet
Department of Employee Insurance
Member Services Branch
501 High Street, Second Floor
Frankfort, Kentucky 40601
888 581-8834
502 564-6534
www.kehp.ky.gov

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

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

Judicial/Legislators Retirement Plans
502 564-5310

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

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

NOTES:

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

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

AN EQUAL OPPORTUNITY EMPLOYER M/F/D
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