Commonwealth of Kentucky
Personnel Cabinet
Department for Employee Insurance

Active Employee Health Insurance Handbook Revised November 3, 2004

Plan Year 2005

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COMMONWEALTH OF KENTUCKY
PERSONNEL CABINET
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Ernie Fletcher
Governor

Robert Ramsey, Sr.
Secretary

Dear Commonwealth Employee:

Over the past five years, the cost of health care has continued to increase. While other employers have struggled with this increase, the Public Employee Health Insurance Program has remained the same.

The Personnel Cabinet's Department for Employee Insurance – along with staff from the Governor's Office, the Finance and Administration Cabinet and the Office of the State Budget Director – has put a great deal of time and effort into reviewing all the options available to our employees with one goal in mind – offering our employees the broadest benefits package possible, while keeping the cost of these benefits at an affordable level for everyone.

This year, the cost sharing aspect of employee benefits has changed, but the covered benefits have remained the same. In addition, some creative new paths – which are detailed in this Handbook – are available as well.

As a participant in the Public Employee Health Insurance Program, I urge you to become an informed consumer. By being informed, you can make the decisions that are most suitable to you and your family. By reviewing this Handbook carefully, attending a Benefit Fair and using the Department for Employee Insurance's Web site (http://personnel.ky.gov/dei.htm), you can find the resources needed to help you take charge of your health and by doing so, take charge of your health care needs.

I hope you will take the time to carefully review this Handbook, and if you have any questions, the Department for Employee Insurance staff is available and more than happy to assist you.

Sincerely,

Esteva Caise Draggs
Executive Director
Department for Employee Insurance

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GENERAL INFORMATION

Disclaimer

Words contained in this Handbook that are ***bold*** and ***italic*** are defined in the "Terms You Need To Know" section.

The material contained in this Handbook is for informational purposes and is not a contract. It is intended only to highlight the benefits and eligibility requirements of the medical plans. Every effort has been made to ensure accuracy; however, should there be a difference between this information and the Plan Documents, the Plan Documents govern. Additionally, should there be a difference between any oral representation provided and the Plan Documents, the Plan Documents govern. 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 eligibility information when applying for coverage, applying for a change of coverage or filing for benefits, the Department for Employee Insurance, or your carrier, may take adverse action against you, including but not limited to, terminating coverage (for you and/or your dependents) and/or imposing liability for fraud or indemnification (requiring payment for benefits to which you and/or your participants were not entitled).

In order to avoid enforcement of any penalties, you must notify the Department for Employee Insurance immediately if a dependent is no longer eligible for coverage or if you have questions or reservations about the eligibility of a dependent.

Who to call

INSURANCE COORDINATOR	HEALTH INSURANCE CARRIER	DEPARTMENT FOR EMPLOYEE INSURANCE
Address changes	Claim questions	General benefit questions
Request forms/handbooks	Referral questions	Plan questions
Eligibility questions/changes	Request provider directories	Obtain HIPAA authorization forms for eligibility
	ID cards (replacements or if you need additional cards)	
	Request HIPAA authorization form for claims	

MEMBER RESPONSIBILITIES

Read this Handbook to learn about your benefits

It is your responsibility to know what benefits are covered, how they are covered and when they are covered. Direct questions to the Department for Employee Insurance and your health insurance carrier. Read your Certificate of Coverage and any other information you receive from your health insurance carrier. Before you have medical services performed, make sure they have been pre-certified, if applicable. Treatment for non-covered services is ultimately your responsibility. If your health insurance carrier does not pay, you are responsible for payment to the provider.

Plan your decisions wisely

Determine which option will best suit your needs and the needs of your family. Determine the amounts that will be deducted from your paycheck. After you have made your selections, you will not be allowed to change them unless you experience a ***Qualifying Event*** that would allow a change.

Complete, sign and submit your application timely

Refer to page 11 for the deadline to submit your Open Enrollment health insurance application. **You MUST complete an application for 2005. If you fail to complete the health insurance application, you will not have health insurance coverage for 2005.** Additionally, if you experience a ***Qualifying Event*** during the Plan Year, you must complete the required application or form within the established deadlines (refer to pages 41 – 48 for details).

Verify that your deductions are correct

It is your responsibility to review your first paycheck for your 2005 Plan Year deductions. For state employees, this is the December 15th paycheck for pay period ending November 30. If it is not accurate, contact your agency's health insurance coordinator. If the option you selected on your Open Enrollment application is not what is being deducted from your paycheck, your agency's health insurance coordinator should contact the Department for Employee Insurance for the necessary corrections. However, if the deductions are consistent with your application, no changes will be allowed.

Notify your agency's health insurance coordinator of any eligibility changes

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

- Birth of a child;
- Adoption of a child or placement for adoption;
- Marriage, divorce, legal separation, annulment;
- Death of spouse or dependent;
- Dependent child reaches 24 years of age;
- An employment status change for you, your spouse, or your dependent(s) that affects eligibility under the plan;
- A Court Order that results in the gain or loss of a dependent; or
- Dependent becomes covered by another group health plan.

IF YOU ARE UNSURE HOW A SPECIFIC EVENT MAY AFFECT YOUR HEALTH INSURANCE, IT IS IN YOUR BEST INTEREST TO CONTACT YOUR AGENCY'S HEALTH INSURANCE COORDINATOR IMMEDIATELY FOR ASSISTANCE.

WHAT IS NEW OR CHANGING?

Beginning January 1, 2005

There are several changes to the Public Employee Health Insurance Program. The Department for Employee Insurance recommends that you carefully read this and all other information you receive from your health insurance carrier prior to making any decision regarding your health insurance.

- Plan Year 2005 is a total re-enrollment. **Every employee must complete a new application. If you fail to complete the health insurance application within the specified timeframe, you and/or your family will not have coverage for 2005.**

- If you are enrolling in a Single plan, you may contribute to the cost of your plan. Refer to the chart on pages 14 – 15 for additional information regarding employee contributions.

- The Commonwealth will offer a premium incentive to employees who do not smoke. If you do not smoke, you will receive an additional $15 contribution per month for single coverage and $30 for dependent coverage toward the cost of your health insurance. This incentive is only applicable to employees electing health insurance coverage. **You must indicate your smoking status as of July 1, 2004 on your health insurance application.**

- The Commonwealth will offer three (3) Preferred Provider Organization (PPO) options – Commonwealth Essential, Commonwealth Enhanced and Commonwealth Premier. For a summary of each option, refer to pages 18 – 22.

- There is only one (1) carrier available in each region. For a list of the regions and the carrier offered by region, refer to pages 16 – 17.

- The cross-reference payment option will be available for 2005 for those employees needing family coverage. The cross-reference payment option is not available for employees needing couple coverage. Both husband and wife must work for an agency participating in the Public Employee Health Insurance Program (herein after referred to as the Program) in order to qualify for the cross-reference payment option. Recipients of the Judicial and Legislators Retirement Plans are NOT eligible to pay by cross-reference.

- **75 Prescription Rule for the Commonwealth Enhanced and the Commonwealth Premier Options only –** When an employee's health insurance contract has paid seventy-five (75) co-payments/co-insurances in

a calendar year for prescription drugs – excluding mail order prescriptions, additional co-payments/co-insurance for retail prescription drugs received during that plan year by any person covered under that contract will be reduced to a $5 co-pay for Generic, a $10 co-pay for Preferred Brand and a $20 co-pay for Non-Preferred Brand. This reduction may be approved at the point of sale or through reimbursement to the covered person no later than thirty-one (31) days after the end of the plan year. Check with your carrier for the individual reimbursement policies.

- In an effort to improve the health of our group, the Commonwealth compiled a list of the top eight (8) medical conditions experienced by its employees. As a result, each carrier is required to offer a Disease Management program for five (5) of the eight (8) medical conditions. Refer to page 30 for additional information regarding Disease Management programs.

- In an effort to be more effective in moving the Public Employee Health Insurance Program from an Illness Model to a Wellness Model program, the Commonwealth is promoting a Wellness Program for its members. Each health insurance carrier is required to have a Health Risk Assessment (HRA) available to you and/or your dependents. Refer to pages 31 – 32 for information regarding HRAs, as well as other wellness initiatives the Commonwealth will offer.

- Applications or Add Forms to add a child(ren) due to adoption, or a child(ren) placed for adoption, must be signed no later than sixty (60) days from the date of adoption or placement for adoption. **Any application or Add Form signed after sixty (60) days will be rejected.** If you plan to add other dependents to your plan at the same time, the application or Add Form must be signed no later than thirty (30) days from the date of adoption or placement for adoption (refer to page 45 for additional information).

- All applications or Add Forms for adding newborns must be completed and signed no later than sixty (60) days from the date of birth. If you wish to add additional dependents with the newborn, the application or Add

Form must be signed no later than thirty (30) days from the date of birth. You will no longer have up to one hundred twenty (120) days to complete the application or Add Form.

- The monthly payment option for health insurance premiums will no longer be available for state employees. Premiums will be deducted each pay period.

- If you elect to waive your health insurance coverage, you may receive a contribution of $234 per month to deposit into a Health Care Flexible Spending Account, if available. You must complete the appropriate Flexible Spending Account application.

OPEN ENROLLMENT INFORMATION

Open Enrollment Dates

Active employees

If you are an active employee, your Open Enrollment will be October 25 – November 5, 2004. The deadline to submit your application to your agency's health insurance coordinator is November 5, 2004.

Retirees and COBRA participants

If you are a retiree or a COBRA participant, your Open Enrollment will be October 25 – November 5, 2004. The deadline to submit your application is November 5, 2004.

- Retirees – you must submit your application to your respective retirement system.
- COBRA participants – you must submit your application to your prior agency's health insurance coordinator.

Processing Note:

1. Complete and sign your application by November 5, 2004
2. Take/Send your application to your agency's insurance coordinator by November 5, 2004
3. Insurance coordinator processes application
4. Insurance coordinator sends to Department for Employee Insurance (DEI)
5. DEI processes application
6. DEI sends application to health insurance carriers
7. Carriers process and mail identification cards to employees

All applications received by the health insurance carriers from the Department for Employee Insurance on or before **December 10, 2004** will receive identification cards by January 1, 2005. Therefore, it is critical that you complete your application as early as possible and that your insurance coordinator forwards your application for processing as quickly as possible. Do not send your application to the carrier.

Applications will be processed in the order they are received.

Failure to complete and sign your application by November 5, 2004 will result in your inability to have coverage on January 1, 2005.

Total Re-Enrollment

Do I have to complete a new application during Open Enrollment?

You **MUST** complete a new application for 2005 even if your current carrier is still available or if you waived coverage for 2004 and wish to continue to waive coverage for 2005. **If you fail to complete a health insurance application, you will not have health insurance coverage for 2005 or a Flexible Spending Account if you are continuing to waive coverage.**

Benefit Fairs

Because of the shortened timeframe for Open Enrollment, no benefit fairs will be conducted by the Commonwealth for the 2005 Plan Year.

KET will broadcast a benefit update throughout Open Enrollment. Check your local listings.

Open Enrollment Steps

What do I have to do during Open Enrollment?

- You should carefully read this Health Insurance Handbook. There have been several changes for 2005. Familiarize yourself with your plan prior to the start of the Plan Year to ensure that you are prepared when a medical need arises.

- If you have a Flexible Spending Account (FSA) program available to you, you should review any information you receive from your employer regarding the FSA program. If you are a state employee, you are eligible for participation in the Commonwealth Choice Flexible Spending Account Program. Review the Commonwealth Choice Handbook.

- You should review pages 16 – 17 to determine which carrier is available in your Region.

- You should review the Benefits Grid on pages 18 – 22 to determine which option best suits you and/or your family's needs.

- You should review all information you receive from health insurance carriers.

- You should contact your agency's health insurance coordinator or the Department for Employee Insurance with any questions regarding your health insurance.

- You MUST complete, sign and return your health insurance application to your agency's health insurance coordinator by the deadline indicated on page 11. If you fail to do so, you will not have health insurance for 2005.

- You MUST complete, sign and return your FSA application if you decide to enroll in a Health Care or Dependent Care Flexible Spending Account. If you are a state employee – the Flexible Spending Account application information is in Section VI of the health insurance application.

PREMIUM/CONTRIBUTION INFORMATION

Contribution Information

Paying your premiums with pre-tax money (state employees) (Premium Conversion)

When you were originally hired, you were set up to have your health insurance premiums paid on a pre-tax basis. If you do not wish to have premiums deducted on a pre-tax basis, you must contact your agency's health insurance coordinator or payroll officer to make a written request to have this changed.

Employee Contributions

Monthly Employee Contribution – Non-Smoker

	Single	Parent Plus	Couple	Family	Family Cross-Reference
Commonwealth Essential	Not offered	$55.00	$259.52	$320.14	$0
Commonwealth Enhanced	$0.00	$114.00	$357.72	$429.24	$9.72*
Commonwealth Premier	$18.20	$170.38	$398.66	$474.74	$33.08*

*Contribution is per employee

Monthly Employee Contribution – Smoker

	Single	Parent Plus	Couple	Family	Family Cross-Reference
Commonwealth Essential	Not offered	$85.00	$289.52	$350.14	$15.00*
Commonwealth Enhanced	$15.00	$144.00	$387.72	$459.24	$24.72*
Commonwealth Premier	$33.20	$200.38	$428.66	$504.74	$48.08*

*Contribution is per employee

Total Monthly Premium by Region

The chart below illustrates the total monthly premium charged to the Commonwealth by region and plan type. This chart is for reference only and does not reflect charges that will be deducted from your pay check.

		Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8
Commonwealth Essential	Single	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Couple	713.99	730.17	679.76	728.04	722.08	854.46	762.48	690.80
	Parent Plus	476.00	486.78	453.20	485.36	481.36	569.64	508.32	460.54
	Family	793.32	811.30	755.32	808.92	802.28	949.40	847.20	767.56
Commonwealth Enhanced	Single	403.28	412.53	394.80	403.96	400.64	496.28	447.52	405.44
	Couple	907.38	928.19	888.28	908.92	901.44	1,116.53	1,006.92	912.24
	Parent Plus	604.92	618.80	592.28	605.96	600.96	744.28	671.28	608.16
	Family	1,008.20	1,031.32	987.02	1,009.92	1,001.60	1,240.52	1,118.80	1,013.60
Commonwealth Premier	Single	412.47	421.95	407.48	422.16	418.64	512.16	474.88	430.24
	Couple	928.06	949.39	916.80	949.88	941.96	1,152.40	1,068.48	968.04
	Parent Plus	618.71	632.93	611.24	633.24	627.96	768.28	712.32	645.36
	Family	1,031.18	1,054.88	1,018.72	1,055.40	1,046.60	1,280.44	1,187.20	1,075.60

Region Selection and Carrier Availability

County or Region

Coverage selection will be based on the region in which you live or work, or if applicable, the region contiguous to the county where you live. Those regions, and the counties associated with the regions, are as follows:

REGION 1

Anthem Blue Cross Blue Shield

Ballard	Caldwell
Calloway	Carlisle
Crittenden	Fulton
Graves	Hickman
Livingston	Lyon
McCracken	Marshall

REGION 2

Anthem Blue Cross Blue Shield

Christian	Daviess
Hancock	Henderson
Hopkins	McLean
Muhlenburg	Ohio
Todd	Trigg
Union	Webster

REGION 3

United Healthcare

Breckinridge	Bullitt
Carroll	Grayson
Hardin	Henry
Jefferson	Larue
Marion	Meade
Nelson	Oldham
Shelby	Spencer
Trimble	Washington

REGION 4

Bluegrass Family Health

Adair	Allen
Barren	Butler
Casey	Clinton
Cumberland	Edmonson
Green	Hart
Logan	McCreary
Metcalfe	Monroe
Pulaski	Russell
Simpson	Taylor
Warren	Wayne

REGION 5	Anderson	Bourbon
	Boyle	Clark
Bluegrass Family Health	Estill	Fayette
	Franklin	Garrard
	Harrison	Jackson
	Jessamine	Lincoln
	Madison	Mercer
	Montgomery	Nicholas
	Owen	Powell
	Rockcastle	Scott
	Woodford	
REGION 6	Boone	Campbell
	Gallatin	Grant
United Healthcare	Kenton	Pendleton
REGION 7	Bath	Boyd
	Bracken	Carter
CHA Health	Elliott	Fleming
	Greenup	Lawrence
	Lewis	Mason
	Menifee	Morgan
	Robertson	Rowan
REGION 8	Bell	Breathitt
	Clay	Floyd
CHA Health	Harlan	Johnson
	Knott	Knox
	Laurel	Lee
	Leslie	Letcher
	Magoffin	Martin
	Owsley	Perry
	Pike	Whitley
	Wolfe	

Plan Codes

CARRIER	PLAN CODE
Anthem Blue Cross Blue Shield	463
Bluegrass Family Health	093
CHA Health	103
United Healthcare	323

BENEFITS

Commonwealth Essential

Covered Services	Commonwealth Essential	
	In-network	Out-of-Network
Annual Deductible	Single - $750 Family - $1,500	Single - $1,500 Family - $3,000
Out-of-pocket maximum (excludes prescription drug expenses and emergency room co-payments)	Single - $3,500 Family - $7,000	Single - $7,000 Family - $14,000
Lifetime maximum	Unlimited	
In-hospital care – provider services, inpatient care, semi-private room, transplant coverage (kidneys, cornea, bone marrow, heart, liver, lungs, heart and lung, and pancreas, or mental health and chemical dependency services	25%*	50%*
Outpatient services – physician or mental health provider office visits, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy; injections, lab fees, X-rays; and mental health or chemical dependency services (members cost includes all services performed on the same day/same site).	25%*	50%*
Diagnostic testing – laboratory tests, X-rays and other radiology or imaging services; and ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury (members cost includes all services performed on the same day/same site).	25%*	50%*
Ambulatory hospital and outpatient surgery services – outpatient surgery services, including biopsies, radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center other than a physician's office.	25%*	50%*

Covered Benefits	In-Network		Out-of-Network
Preventive care – annual gynecological exam, well child care, and routine physical early detection tests, subject to age and periodicity limits.	Plan pays 100% up to a maximum of $200 per covered individual. Plan pays 100% of eligible immunizations.		
Emergency services			
Emergency room treatment (Emergency room co-pay waived if admitted).	$50 co-pay plus 25%*		$50 co-pay plus 50%*
Emergency room physician charges	25%*		50%*
Urgent care center treatment	25%*		50%*
Ambulance services	25%*		50%*
Maternity care – prenatal care, labor, delivery, postpartum care, and one ultrasound per pregnancy. Additional ultrasounds subject to prior plan approval.	25%*		50%*
Prescription drugs – Retail (30 day supply)	25%		
	Min	Max	
Generic	$10	$25	
Preferred Brand	$20	$50	
Non-preferred Brand	$35	$100	
Prescription drugs – Mail Order (90 day supply)	25%		
	Min	Max	
Generic	$20	$50	
Preferred Brand	$40	$100	
Non-preferred Brand	$70	$200	
Audiometric services in conjunction with a disease, illness or injury	25%*		50%*
Chiropractic services – limited to 26 visits per year, with no more than one visit per day	25%*		50%*
Autism Service			
Rehabilitative and therapeutic care services	25%*		50%*
Respite care for children ages two through 21 ($500 maximum per month)	25%*		50%*
Hospice care – subject to precertification by the plan	Covered the same as under the federal Medicare program		
Durable Medical Equipment	25%*		50%*
Prosthetic devices	25%*		50%*
Home health – limited to 60 visits per year	25%*		50%*

Covered Services	In-Network	Out-of-Network
Physical therapy – limited to 30 visits per year	25%*	50%*
Occupational therapy – limited to 30 visits per year	25%*	50%*
Cardiac rehabilitation therapy – limited to 30 visits per year	25%*	50%*
Speech therapy – limited to 30 visits per year	25%*	50%*
Skilled nursing facility services – limited to 30 days per year	25%*	50%*
Hearing aids – individuals under 18 years of age, limited to one per ear every three years and a maximum benefit of $1,400 per ear	25%*	50%*

*Services subject to deductible

Commonwealth Enhanced and Commonwealth Premier Benefits Grid

Covered Services	Commonwealth Enhanced		Commonwealth Premier	
	In-network	Out-of-Network	In-network	Out-of-Network
Annual Deductible (excludes office visit co-pay, preventive care services, outpatient diagnostic testing, urgent care center, prescription drugs, chiropractic services and hospital emergency room services)	Single - $250 Family - $500	Single - $500 Family - $1,000	Single - $250 Family - $500	Single - $500 Family - $1,000
Out-of-pocket maximum (excludes prescription drug co-pays, office visits, hospital emergency room visits and urgent care services)	Single - $1,250 Family - $2,500	Single - $2,500 Family - $5,000	Single - $1,000 Family - $2,000	Single - $2,000 Family - $4,000
Lifetime maximum	Unlimited		Unlimited	
In-hospital care – provider services, inpatient care, semi-private room, transplant coverage (kidneys, cornea, bone marrow, heart, liver, lungs, heart and lung, and pancreas), and mental health and chemical dependency services	20%*	40%*	10%*	30%*
Outpatient services – physician or mental health provider office visits, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well child care, immunizations, injections, lab fees, x-rays; and mental health or chemical dependency services (members cost includes all services performed on the same day/same site).	$10 co-pay	40%*	$10 co-pay	30%*
Outpatient diagnostic testing – laboratory tests, x-rays and other radiology or imaging services; and ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury (members cost includes all services performed on the same day/same site).	$10 co-pay	40%*	$10 co-pay	30%*
Ambulatory hospital and outpatient surgery services – outpatient surgery services, including biopsies, radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center other than a physician's office.	20%*	40%*	10%*	30%*
Preventive care – annual gynecological exam, routine physical and early detection tests, subject to age and periodicity limits.	$10 co-pay per visit	40%*	$10 co-pay per visit	30%*
	$400 maximum benefit per covered individual per plan year		$400 maximum benefit per covered individual per plan year	
Emergency services				
Emergency room treatment (Emergency room co-pay waived if admitted).	$50 co-pay plus 20%	$50 co-pay plus 40%	$50 co-pay plus 10%	$50 co-pay plus 30%*
Emergency room physician charges	20%	40%	10%	30%*
Urgent care center treatment	$20 co-pay	40%*	$20 co-pay	30%*
Ambulance services	20%*	20%*	10%*	30%*
Maternity care – prenatal care, labor, delivery, postpartum care, and one ultrasound per pregnancy. Additional ultrasounds subject to prior plan approval. Office visit co-pay is limited to the office visit in which pregnancy is diagnosed. Thereafter, no co-pay required.	$10 co-pay in-hospital care co-insurance applies*	40%*	$10 co-pay in-hospital care co-insurance applies*	30%*
Prescription drugs – Retail (30 day supply)				

Covered Services	Commonwealth Enhanced		Commonwealth Premier	
	In-network	Out-of-Network	In-network	Out-of-Network
Generic Preferred Brand Non-preferred Brand	$10** $15** $30**	40% 40% 40%	$10** $15** $30**	30% 30% 30%
Prescription drugs – Mail Order (90 day supply) Generic Preferred Brand Non-preferred Brand	 $20 $30 $60		 $20 $30 $60	
Audiometric services in conjunction with a disease, illness or injury	50%*	50%*	10%*	30%*
Chiropractic services – limited to 26 visits per year, with no more than one visit per day	$10 co-pay	40%*	$10 co-pay	30%*
Autism Service				
▪ Rehabilitative and therapeutic care services	$10 co-pay	40%*	$10 co-pay	30%*
▪ Respite care for children ages two through 21 ($500 maximum per month)	50%*	50%*	10%*	30%*
Hospice care – subject to precertification by the plan	Covered the same as under the federal Medicare program		Covered the same as under the federal Medicare program	
Durable Medical Equipment	20%*	40%*	10%*	30%*
Prosthetic devices	20%*	40%*	10%*	30%*
Home health – limited to 60 visits per year	20%*	40%*	10%*	30%*
Physical therapy – limited to 30 visits per year	20%*	40%*	10%*	30%*
Occupational therapy – limited to 30 visits per year	20%*	40%*	10%*	30%*
Cardiac rehabilitation therapy – limited to 30 visits per year	20%*	40%*	10%*	30%*
Speech therapy – limited to 30 visits per year	20%*	40%*	10%*	30%*
Skilled nursing facility services – limited to 30 days per year	20%*	40%*	10%*	30%*
Hearing aids – individuals under 18 years of age, limited to one per ear every three years and a maximum benefit of $1,400 per ear	20%*	40%*	10%*	30%*

*subject to annual deductible
** After the 75th prescription has been filled, excluding mail order, the co-payment will reduce to $5 generic, $10 preferred brand and $20 non-preferred brand.

General Benefit Information

Providers

The carriers' provider directories and prescription drug formularies are subject to change throughout the year. Although your physician may be participating with your carrier as of January 1, that does not guarantee he or she will remain with the plan throughout the year. **Providers may discontinue participation with carriers at any time during the year. This is not a *Qualifying Event* to allow you to change your coverage elections.**

Provider directories are also available on the carriers' respective Web sites (refer to page 72 for telephone numbers and Web site addresses). If you do not have Internet access, you may call your carrier's customer service number for any updates.

Balance Billing

If you use ***out-of-network*** providers, you may be "***balance billed***" for any amount not paid for by your insurance carrier. This means the provider (doctor, hospital or other medical providers) will bill you for the amount that your insurance carrier did not pay (above ***Usual, Customary and Reasonable*** or non-covered services), in addition to your ***cost-sharing*** and ***deductible***, if applicable. Contact the carrier for additional information.

Pre-existing Conditions

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

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

- pregnancy,
- domestic violence,
- genetic information in the absence of a diagnosis for such a condition,
- newborn children
- adopted children or children placed for adoption who are under 24 years of age.

Co-insurance and Out-of-pocket Maximums

- ***Deductibles*** and ***out-of-pocket*** limits between ***in-network*** and ***out-of-network*** services are combined.
- Emergency room co-payment (but not ***co-insurance***) is waived if admitted to the hospital.
- ***Deductibles***, out-of-pocket limits, and ***co-insurance*** accumulated with one carrier will transfer to your new carrier if you must select a new carrier during the Plan Year due to an appropriate ***Qualifying Event***.
- ***For the Commonwealth Essential, co-insurance*** for prescription drugs does not apply to the ***maximum out-of-pocket*** limit.
- ***For the Commonwealth Enhanced and Commonwealth Premier, co-pays for office visits, prescription drugs and emergency room visits do not apply to the maximum out-of-pocket limit.***

Medical Services

- Ultrasounds, in excess of one per pregnancy, require prior plan approval.
- Chiropractor visits are covered at the same benefit level as physician office visits (except annual visit limit applies to chiropractic exams). No referral is necessary.
- Ambulance coverage is limited to ground transportation unless a life threatening situation exists where air ambulance is medically necessary.
- Kidney, cornea, bone marrow, heart, liver, lung, heart/lung and pancreas transplants are covered.

Preventive Services

All plans will provide benefits for the following preventive services subject to maximum benefit limits (refer to the Benefits Grid on pages 18 – 22 for details):

- Annual PAP test.
- Annual routine physical.
- A mammogram covered one time between the ages 35-39 and annually for persons age 40 and older.
- Sigmoidoscopy covered at age 50 and every year thereafter.

- Cardiac risk profile blood test beginning at age 35 and every five years thereafter.
- Glucose serum test covered for all ages.
- EKG covered at age 40 and every year thereafter.
- PSA (prostate exam) covered at age 50 and every year thereafter.

General Benefit Information - Reminders

- You do not need to select a primary care physician (PCP).
- You will not be ***balance billed*** if you use participating PPO providers.
- Your out-of-pocket cost per year is limited. Once your ***deductible*** and ***co-insurance*** total the annual out-of-pocket maximum, benefits (excluding office visit co-pays, prescription drug co-pays and/or co-insurance and emergency room co-pays) are paid at 100% for the remainder of the year.
- You may access any licensed ***out-of-network*** physician, specialist or hospital at any time. However, you will pay more for ***out-of-network*** services, and charges are subject to ***balance billing***. These charges are your responsibility.
- Some physicians affiliated with your carrier's PPO networks may not accept new patients or may cease participation during the year. Check with the physician(s) of your choice and your health insurance carrier.
- Become familiar with the requirements of your plan before you need to use it. Contact your carrier with any questions you may have prior to receiving services.
- Confirm that your doctor, hospital or pharmacy is participating with your plan. All carriers have updated provider directories on their Web site. If you have access to the Internet, confirm participation on the Web site. If you do not have access to the Internet, contact your carrier's customer service number on the back of your identification card for confirmation. Utilizing a non-participating provider will result in higher ***co-insurance*** for you.
- Most plans require ***pre-certification*** for certain medical procedures such as overnight hospital stays, outpatient or elective surgery, diagnostic procedures, home health care services, etc. It is your responsibility to ensure that ***pre-certification*** is obtained prior to receiving

services. Check with your health care provider to make sure the services have been pre-authorized.

- Some prescription drugs may require prior authorization. Check with your carrier to determine if your prescription requires prior authorization.

Prescription Drugs

Prescription Drug Coverage

If you request a brand name drug when a generic drug is prescribed, you will pay the brand name ***co-pay/co-insurance*** plus the cost difference between the brand name and the ***generic drug***.

The ***co-pay/co-insurance*** for prescription drugs purchased at a retail pharmacy applies to each one-month or 30-day supply.

Each health insurance carrier has an established list of preferred drugs (***formulary***). This ***formulary*** is subject to change during the Plan Year. Decisions for inclusion on the preferred list are based on the drug's safety, effectiveness and cost. Some drugs require prior authorization before the carrier will cover any of the cost. **Remember, this preferred drug list varies by carrier and is subject to change during the year.**

The prescription drug benefit offered by most plans usually covers FDA approved ***generic drugs***, as well as many brand name drugs. Usually, several "non-preferred" medications are available without prior authorization upon payment of an additional ***co-pay/co-insurance***. Each plan has certain drugs that, due to the nature of the medication, require prior authorization before the plan will cover any portion of the cost. These drugs are not automatically available. In most instances, only physicians may request prior authorizations as they are based on your medical history. Some plans also establish drug use guidelines in an effort to promote the appropriate use of certain medications. These guidelines may require you to try a drug that has been in use for a longer time before the plan will approve payment for a new and perhaps more expensive alternative.

Prescription drugs for the treatment of non-covered medical services are not covered under the plan.

Mail Order Prescription Drugs

Each plan offered by the Program includes an optional Mail Order Prescription Drug benefit that provides for a 3-month or 90-day supply of maintenance drugs for the cost of a 2-month or 60-day supply. The only maintenance drugs that

may be dispensed through mail order are those for which there have been at least 3 claims for a 30-day supply within the last 4 months, or at least 1 claim for a 90-day supply in the last 6 months, including a mail order prescription. Further, the drug must be required for maintenance therapy as determined by the prescribing provider. The prescription must be written for a 90-day supply with refills, if necessary.

The mail order option shall not permit the dispensing of a controlled substance classified as Schedule II.

A health insurance carrier shall not discriminate against any retail pharmacy located within the geographic coverage area of the health benefit plan and that meets the terms and conditions for participation established by the insurer, including price, dispensing fee, and ***co-insurance*** requirements of a mail order option. The retail pharmacy shall not be required to dispense by mail.

Commonwealth Essential – Prescription Drug Benefit – **Retail**

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

- Generic - $10 minimum/$25 maximum
- Preferred Brand - $20 minimum/$50 maximum
- Non Preferred Brand - $35 minimum/$100 maximum

Mail Order

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

- Generic - $20 minimum/$50 maximum
- Preferred Brand - $40 minimum/$100 maximum
- Non Preferred Brand - $70 minimum/$200 maximum

See chart below for further clarification.

Commonwealth Essential		
If the cost of your generic drug is:	**For retail, you pay:**	**For Mail Order, you pay**
Less than $10.00	Cost of Drug	Cost of Drug
$10.01 - $40.00	$10.00 minimum	$20.00 minimum *
$40.01 - $100.00	25% of cost	3 month supply you pay 25% of cost for 2 month's supply
More than $100.00	$25.00 maximum	$50.00 maximum *

If the cost of your preferred drug is:	**For retail, you pay:**	**For Mail Order, you pay**
Less than $20.00	Cost of Drug	Cost of Drug
$20.01 - $80.00	$20.00 minimum	$40.00 minimum*
$80.01 - $200.00	25% of cost	3 month supply you pay 25% of cost for 2 month's supply
More than $200.00	$50.00 maximum	$100.00 maximum*

If the cost of your non-preferred drug is:	**For retail, you pay:**	**For Mail Order, you pay**
Less than $35.00	Cost of Drug	Cost of Drug
$35.01 - $140.00	$35.00 minimum	$70.00 minimum*
$140.01 - $400.00	25% of cost	3 month supply you pay 25% of cost for 2 month's supply
More than $400.00	$100.00 maximum	$200.00 maximum*

*Two (2) month's cost for three (3) months of medication.

Disease Management

What is Disease Management?

Disease Management is a voluntary program that gives you and your covered dependent(s) the information and support needed to live well with chronic conditions. Disease Management programs will help reduce health care costs by identifying high-cost and high-risk patients and educating those patients to become better engaged in their own care management. Disease Management programs should target the most costly diseases in an employer group's population and those that offer the greatest potential for savings from improved provider practices and patient self-management. Disease Management programs improve care quality and health outcomes.

Why is the Commonwealth requiring health insurance carriers to offer Disease Management programs?

The number of Kentuckians suffering from chronic diseases is rapidly increasing. Chronic conditions affecting children, such as asthma, allergies and diabetes, are on the rise, and chronic conditions are becoming more prevalent as our population ages. Disease Management programs are designed to reduce health care costs, prevent unnecessary health complications, and improve health outcomes for the chronically ill.

What Disease Management programs will be offered through the Program?

Based upon a review of the Program's health care expenditures, Disease Management programs for the following conditions would have the greatest benefit:

Arthritis
Asthma
Chronic Obstructive Pulmonary Disease (COPD)
Coronary Artery Disease (CAD)
Depression
Diabetes
Hypertension
Low back pain

The Commonwealth requires that all carriers have Disease Management programs that address at least five (5) of the eight (8) diagnoses listed above. Your carrier may offer additional Disease Management programs. If you or one of your covered family members has one or more of the conditions listed above, check with your health insurance carrier for additional information.

Wellness Program

The Commonwealth Wellness Program

The Commonwealth's Wellness Program is designed to encourage you and your family to adopt healthier lifestyles. The Department for Employee Insurance envisions this model as an important part of the health insurance program adopted by the Commonwealth.

As a component of the Governor's Wellness Initiative, each health insurance carrier is required to offer participants of the Program access to Health Risk Assessments (HRAs).

What are Health Risk Assessments and what do they do?

Health Risk Assessments

An HRA is a tool used to give you a snapshot of your individual health risks based on your family history, general health and lifestyle behaviors. HRAs give you the opportunity to take time out to review both your physical condition as well as your lifestyle to ensure your continued health and well being. An HRA also enables you to take control of your health for the future.

HRAs were introduced more than twenty (20) years ago as a way for an individual to assess their risk for certain medical conditions. HRAs generally ask questions about family history, general health parameters (weight, height, blood pressure, etc.) and lifestyle behaviors (diet, tobacco, alcohol use, safety precautions, etc.). Upon completion of an HRA, a summary of your various health risks and lifestyle behaviors will be issued with suggestions on how to reduce risk for disease. HRAs are extremely useful in assessing individual and group health risks. However, they are not substitutes for medical histories or medical exams.

Will my employer be given a copy of my HRA or a copy of my results?

Absolutely not. Your individual HRA, and the corresponding results will not be shared with the Commonwealth or your employer.

HRA summary results

Each health insurance carrier is required to provide the Commonwealth with combined data from all HRAs. There will be no identifying data that would connect the results to an individual. It will be summary data compiled from every HRA completed by members of the Program.

What will the Commonwealth do with the data?

The Commonwealth will use this summary data to evaluate the health status of its group. This data will be used in conjunction with data received from the Commonwealth's health insurance carriers to develop future Wellness Programs that will target the specific needs of our group.

How do I obtain or take an HRA?

Each health insurance carrier is required to offer an HRA to members of the Public Employee Health Insurance Program. Health insurance carriers will have HRAs available through their Web site. HRAs completed on the Web site will allow you to get results online, in a secure format. If you do not have access to the Internet and wish to complete an HRA, contact your health insurance carrier and they will mail you an HRA to complete. Mail the completed HRA back to the carrier and they will mail you the results.

What other Wellness Programs will the Commonwealth be offering?

Governor's Wellness Walk

In an effort to be more effective in moving the Public Employee Health Insurance Program from an Illness Model to a Wellness Model, the Governor supports a walking program to be held in conjunction with the health insurance program.

The "Governor's Wellness Walk" will be a walking program available to State employees. The goals of the "Governor's Wellness Walk" will be to increase physical activity; to increase educational awareness of the benefits of walking; to motivate employees to make positive health behavioral changes; and to collect data to support future wellness program decisions.

Further information on this and other programs will be forthcoming. Check the Department for Employee Insurance's Web site for more information throughout the year for updates.

Will the health insurance carriers have any Wellness Programs?

For the 2005 Plan Year, the only Wellness Program required of our health insurance carriers is to have an HRA available to you. However, some health insurance carriers may offer additional Wellness Programs. Check with your health insurance carrier to see what other programs they may have available.

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. Your Certificate of Coverage from your carrier 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:

- Services related to a pre-existing condition in the first 12 months of coverage (the 12 months may be reduced by any creditable coverage you bring to the Plan);
- Abortion;
- Acupuncture;
- Cosmetic Services;
- Custodial care, including sitters and companions;
- Dental services except as otherwise specifically provided;
- Equipment that has a non-therapeutic use (such as humidifiers, air conditioners, whirlpools, artificial hair replacement or fitness supplies);
- Experimental or Investigational Services;
- Eyeglasses, contact lenses (unless medically necessary after cataract surgery) and routine eye examinations;
- Infertility;
- Over-the-counter contraceptive devices;
- Over-the-counter drugs;
- Refractive surgery such as radial keratotomy and other procedures to alter the refractive properties of the cornea;
- Services performed by the insured or a relative;

- Services for job, occupational or school placement or for educational purposes;

- Services, supplies, drugs or other care not medically necessary for the diagnosis or treatment of a physical or mental illness, injury or symptomatic complaint;

- Services or supplies for any condition, disease, ailment, or accidental injury arising in the course of employment;

- Sex Transformation/Sexual Dysfunction or inadequacies; and

- Weight reduction programs or treatment for obesity (except for surgery for morbid obesity where the condition is of a life-threatening nature to the covered person).

For additional exclusions, refer to the Certificate of Coverage you receive from your health insurance carrier.

ENROLLMENT AND ELIGIBILITY

Eligible Participants

Full-time employees	**Regular full-time employees of the following agencies who contribute to one of the state-sponsored retirement systems are eligible to participate:** ▪ State Agencies ▪ Boards of Education ▪ Health Departments ▪ KCTCS ▪ Members of additional groups whose employers pay into a state-sponsored retirement system and have elected to participate in the Public Employee Health Insurance Program.
Retirees	**Retirees under age 65 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) ▪ KCTCS
Other eligible participants	Eligible COBRA participants.
Limitations	Employees, retirees, COBRA participants and their dependents may only be covered under **one** state-sponsored plan.

Eligible Dependents

A dependent is:	▪ A member's spouse under an existing legal marriage; ▪ A member's unmarried child from birth to age twenty-four (24) who resides with the member in a parent-child relationship and who is dependent on the member for more than 50% of his/her maintenance and support. For purposes of determining eligibility, the term "child" includes a (1) natural child, (2) stepchild by an existing legal marriage, (3) child legally placed for adoption with, or legally adopted by, the member, (4) foster child, and

(5) grandchild and/or a child for whom full legal guardianship has been awarded;

- A member's unmarried child who does not reside with the member in a parent-child relationship, but for whom the member or his/her spouse has a legal obligation under a divorce decree, court order or administrative order to provide for the health care expenses of the child.

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

An eligible dependent child is covered to the end of the month in which he/she turns twenty-four (24).

For purposes of this definition, a divorced dependent is not an "unmarried" dependent.

Eligibility may continue past the age limit for an unmarried child covered under the Plan who is totally disabled and unable to work to support himself/herself due to a mental or physical disability that started before the age limit and is medically certified by a physician. The carrier may require proof of the dependent's disability no more than once per year.

- 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 continuous or indefinite duration. The carrier must approve total disability.

Levels of Coverage

Participants in the Program are eligible to enroll in the following levels of coverage:

- **Single** – Covers the employee/retiree ONLY
- **Parent Plus** – Covers a married or single employee/retiree and one or more children, but does not cover the spouse
- **Couple** – Covers an employee/retiree and his/her legal spouse
- **Family** – Covers an employee/retiree, his/her legal spouse and one or more children

Contiguous County

What is a contiguous county?

Legislation was passed during the 2003 Legislative Session amending the options for selecting health insurance coverage. Please read the following section carefully as it does not apply to all counties in the Commonwealth. KRS 18A.225 has been amended as follows:

> If a state employee's residence and place of employment are each located in counties in which the hospitals do not offer surgical services, intensive care services, obstetrical services, level II neonatal services, diagnostic cardiac catheterization services and magnetic resonance imaging services, the employee may select a plan available in a county contiguous to the county of residence that does provide those services, and the state contribution for the plan shall be the amount available in the county where the plan selected is located.

A contiguous county is a county in Kentucky that shares any portion of its border with another county within the Commonwealth of Kentucky.

Based on the contiguous county Legislation, employees living in any county in the "county" column may select coverage from the "region" column.

County	Region
Caldwell	Region 1 or 2
Casey	Region 4 or 5
Crittenden	Region 1 or 2
Hart	Region 3 or 4
Laurel	Region 4 or 8
Lincoln	Region 4 or 5
Marion	Region 3 or 5
Rockcastle	Region 4 or 5
Washington	Region 3 or 5

Waiver of Coverage

Waiving your Health Insurance

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

If you are a new employee and wish to waive coverage, you must complete Sections I, II, #2, and VII of the health insurance application and turn it in to your agency's health insurance coordinator no later than thirty (30) days after your employment date.

If you are enrolled in a health insurance plan for 2004 and wish to waive coverage for 2005, you must complete Sections I, II, #2 and VII of the health insurance application during Open Enrollment.

If you waive coverage in 2004 and wish to waive coverage in 2005, you MUST complete a new application. You must complete Sections 1, II, #2 and VII of the health insurance application during Open Enrollment.

Waiving coverage and directing state money to a Health Care Flexible Spending Account

If you waive your health insurance provided by the Commonwealth, you may be eligible to receive a $234 employer contribution to direct into a Health Care Flexible Spending Account. However, in order to do so, you must enroll in a Flexible Spending Account.

- If you are a state employee, you are eligible for the Commonwealth Choice Health Care Flexible Spending Account. You must complete Section VI of the health insurance application.
- If you are an employee of any other agency, you may be eligible to direct the $234 employer contribution to a Health Care Flexible Spending Account. Contact your agency's health insurance coordinator for more information.

Retirees are not eligible for participation in a Flexible Spending Account Program.

Effective Dates

New Employees

If you are an employee of:

- State Agencies;
- Boards of Education;
- Health Departments; or
- KCTCS

You have thirty (30) days from the date you are hired to:

- Enroll in a plan that is offered in the county where you live, work or, if applicable, a contiguous county (refer to page 37); or
- Waive (decline) coverage by completing Sections I, II #2 and Section VII of the health insurance application. If you are a state employee and you wish to enroll in a Health Care Flexible Spending Account, you must also complete Section VI of the health insurance application.

Applications are available from your agency's health insurance coordinator.

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

If you are an employee of groups other than those listed above, you may have different guidelines regarding your effective date of coverage. You may have a waiting period longer than the first day of the second calendar month. Contact your agency's health insurance coordinator for details. Applications must be signed thirty (30) days prior to the coverage effective date.

Open Enrollment

All elections made during Open Enrollment will be effective January 1, 2005.

***Qualifying Events* – adding dependents or changing coverage elections**

Refer to pages 41– 48 for information regarding ***Qualifying Event*** effective dates.

Termination Dates

Terminating Employment	The Program is a pre-paid health insurance plan. Therefore, your health insurance will terminate on the last day of the second month following the date in which your employment terminates. For example, if you terminate employment effective March 15, your health insurance coverage will terminate April 30. If you terminate employment effective March 31, your coverage will terminate April 30.
Dependents dropped during Open Enrollment	Any change made during Open Enrollment that would terminate your plan or drop any dependents from your plan will be effective December 31, 2004.
***Qualifying Events* – dropping dependents**	Refer to pages 41 – 48 for information regarding ***Qualifying Event*** effective dates.
Termination for non-payment of premiums	A health insurance carrier has the right to terminate your coverage if premiums are not paid in full each month. The health insurance carrier will notify the Department for Employee Insurance to terminate an employee's coverage for non-payment. The coverage will be terminated at the end of the last month for which premiums were paid in full.

Qualifying Events

The Commonwealth of Kentucky's Public Employee Health Insurance Program is provided through a Section 125 plan. This allows you to pay for your health insurance premiums with pre-tax monies, which saves you money. Section 125 plans are federally regulated. Federal guidelines state that if your health insurance is offered through a Section 125 plan, you cannot make a change in your health insurance option outside of the Open Enrollment period unless you experience an appropriate ***Qualifying Event***. ***Qualifying Events*** are also governed by federal guidelines and the Department for Employee Insurance cannot modify the ***Qualifying Events*** it has adopted for use in this Program.

If you experience a ***Qualifying Event*** during the Plan Year, you are allowed to make changes to your health insurance coverage. Those allowed changes must be consistent with and on account of the ***Qualifying Event*** you experience.

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 Add Form. Keep in mind that the Program is a pre-paid health insurance program. If you experience a ***Qualifying Event*** that allows you to add dependents, you may be in arrears for payment of premiums. If this happens, you will be responsible for any premiums due.

Exceptions:

Birth – children added due to this ***Qualifying Event*** are effective on the date of birth, if application is completed within the specified timeframe.

Adoption/Placement for adoption – children added due to this ***Qualifying Event*** are effective on the date of adoption or placement for adoption, if application is completed within the specified timeframe.

To drop dependents:

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

current coverage. Health coverage for dependents dropped from a plan ends on the last day of the month in which the employee signs the Drop Form.

Exceptions:

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

Carrier changes

The ***Qualifying Event*** "Moving Out of the Service Area" may allow an employee to make a change to his/her existing carrier. This occurs when an employee moves out of his/her selected county of coverage (home or work, or contiguous, if applicable) into another county where the employee's existing carrier is not available.

Example:

Employee has coverage in her home county and she moves her residence to a different county in which her carrier is not available. In this case, the employee will be allowed to:

- Change her coverage elections to a carrier that is available in the new home county; or
- Change her county of coverage from home to work in order to keep her existing coverage elections (providing that the existing elections are available in her work county).

- If an employee has coverage in her work county and she moves her residence (home county) to a different county in which her carrier is not available, the employee will not be allowed to make a change in carrier because her coverage is still available in her county of choice (work).
- Changes in options during the Plan Year are not allowed.

Deadlines

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

Exceptions:

Adding a newborn only – employee has 60 days*

Adoption/Placement for adoption – employee has 60 days*

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

Special Processing Guidelines

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

Exceptions:

- **Notification Date:** This is the date the employee is notified by another source that an event affecting his/her eligibility for a different coverage has occurred. The Department for Employee Insurance will accept a notification date (in lieu of the event date) only in the following cases:
  - Eligibility for governmental programs (Medicare, Medicaid, Loss of KCHIP)
  - CHAMPVA
  - TRICARE

Applications for changes due to a ***Qualifying Event*** cannot be signed before the event occurs.

Exceptions:

- **Pre-Signing:** This is the ability of an employee to sign a form prior to a ***Qualifying Event*** taking place. The Department for Employee Insurance will accept a pre-signed form only in the following cases:
  - Loss of Other Group Health Coverage*
  - Entitlement to Medicare*
  - Spouse/Retiree has a Different Open Enrollment Period - See below for details.

The effective dates of the indicated **Qualifying Events are determined following the same guidelines as indicated under "Effective Dates" on page 41 of this section. Therefore, pre-signing an application or form may result in double coverage or a gap in coverage.*

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 be manually entered to correspond with the effective date of the spouse/retiree's open enrollment elections.

Moving Out of the Service Area: The effective date of this ***Qualifying Event*** is the first day of the month following the employee's signature date. Calculation of effective dates with the newly selected coverage will be done prospectively.

How do I know which form to use to make a change?

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

- Initial enrollment at hire date (New Employee)
- Open Enrollment
- If you are employed by a group that joins the Public Employee Health Insurance Program for the first time (New Group)
- If you, or your dependents, elect to continue coverage through COBRA;
- If you move out of the service area
- Other or Previously Waived – if you previously waived or marked "other", you must enter the ***Qualifying Event*** date and a description of the ***Qualifying Event***.

You should use the Add Form if:

You are currently enrolled and you experience a ***Qualifying Event*** that allows you to add any dependents to your plan.

You should use the Drop Form if:

You are currently enrolled and you experience a ***Qualifying Event*** that allows you to drop any dependents from your plan.

Supporting Documentation

Divorce/Legal Separation

If dropping spouse from plan:

- Filed decree signed by a judge and date-stamped "filed."

If enrolling because event caused loss of other coverage:

- Proof that you were covered under your spouse's plan and no longer eligible (HIPAA certificate or letter from employer). Letter should identify date of insurance termination and persons who were covered by policy.

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

Adoption or Placement for Adoption

- 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.

Judgment decree or Administrative Order relating to health coverage for your child

- A filed or dated court decree;
- Agency Administrative Order; or
- National Medical Support Notice.

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

- Initial eligibility letter from the Medicare/Medicaid Office

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

Loss of other group health insurance coverage that entitles employee or family member to be enrolled in accordance with HIPAA

- HIPAA certificate from prior carrier;
- Letter from employer/previous employer (letter should identify date of insurance termination and persons who were covered by policy); or
- Termination letter from government agency under which previous coverage was held.

Adding a grandchild

- Guardianship papers.

Guidelines for adding children

Biological children

- Can be added to your coverage by selecting the ***Qualifying Event*** of *Birth (newborn only)* or *Birth plus other dependents* on the Add Form.

- The effective date of coverage for children added due to this ***Qualifying Event*** is the child's date of birth (DOB).

- The deadline to add a newborn only is sixty (60) days from the DOB; the deadline to add a newborn plus other dependents is thirty (30) days from the date of birth.

- No supporting documentation is required.

Adopted children or children placed for adoption

- Can be added to your coverage by selecting the ***Qualifying Event*** of *Adoption/Placement for adoption (adopted child only)* or *Adoption/placement for adoption plus other dependents* on the Add Form.

- The effective date of coverage is the adoption date or the date the children is placed for adoption.

- The deadline to add an adopted child or a child placed for adoption only is sixty (60) days from the adoption or placement date. The deadline to add an adopted child or a child placed for adoption plus other dependents is thirty (30) days from the adoption or placement date.

- The supporting documentation required is listed on pages 45 – 46 under “Supporting Documentation”.

Children other than biological or adopted children (Grandchildren, stepchildren, foster children and other children) (refer to pages 35 – 36 for the definition of dependents).

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

- The effective date of coverage is the first day of the first month after the employee’s signature on the Add Form.

- The deadline to add children under this ***Qualifying Event*** is no later than thirty (30) days from the ***Qualifying Event***. The ***Qualifying Event*** date is the date that the Legal Guardianship, Court Order or Administrative Order is obtained.

- The Add Form cannot be signed before the ***Qualifying Event*** occurs.

- The supporting documentation required:
  - to add grandchildren is Legal Guardianship papers;
  - to add foster children is a Letter from the Cabinet for Health and Family Services;
  - 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 35 – 36.

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

Important Facts

- The appropriate form must be completed and signed within the specified deadlines. Applications/forms signed after the appropriate deadlines will not be accepted.

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

- A list of the permitted ***Qualifying Events*** and necessary forms are included in the Department for Employee Insurance Web site at http://personnel.ky.gov/dei.htm. You may also contact your agency's health insurance coordinator or the Department for Employee Insurance's Member Services Branch for additional information regarding ***Qualifying Events***.

GRIEVANCES

To the Public Employee Health Insurance Program

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

Grievances must be filed in writing to:

Personnel Cabinet
Department for Employee Insurance
Attention: Grievance Committee
200 Fair Oaks Lane, Suite 502
Frankfort, KY 40601

A grievance must include ALL of the following items:

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

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

A written response will be mailed to you and your agency's health insurance coordinator stating the decision of the Committee.

The Committee will not review a second request **unless** additional relevant facts are provided.

To the Health Insurance Carrier

Each health insurance carrier is required by law to print its Grievance Procedures in its Certificate of Coverage. Please refer to your carrier's Certificate of Coverage for information regarding carrier specific Appeals and Grievances.

FEDERAL REGULATIONS

Section 125 – Cafeteria Plan

What is a Cafeteria Plan?

The Commonwealth Program is provided through a ”cafeteria plan” plan. This allows you to pay for your health insurance premiums with pre-tax monies. Cafeteria plans are federally regulated (Internal Revenue Code Section 125). These guidelines state that your health insurance cannot be changed outside of the Open Enrollment period unless you experience an appropriate ***Qualifying Event***. ***Qualifying Events*** are also governed by federal guidelines and the Department for Employee Insurance cannot modify the ***Qualifying Events*** it has adopted for use in this program.

Portability of Prior Coverage

What is portability of prior coverage?

When you and your dependents are enrolled in the Program, you are subject to a twelve (12) month pre-existing condition limitation.

If you previously had other health care coverage defined as “creditable coverage” under HIPAA, and that other coverage terminated within 63 days of the date of coverage under the Program, your prior health coverage will be credited toward the twelve (12) months pre-existing condition exclusion period.

Federal law requires that your prior health insurance carrier provide you with a Certificate of Creditable Coverage. If you have not received that information, you should contact your carrier.

Coverage for you and/or your dependents will terminate the last day of the month following the month that you cease to meet the eligibility guidelines. According to COBRA laws, coverage may be continued beyond that date in the following instances:

Leave of absence;
Family and Medical Leave;
Surviving Family; or
Over age Dependents.

For additional information on continuing coverage with COBRA, please refer to pages 55 – 61 or check with your agency's health insurance coordinator.

Women's Health and Cancer Rights Act of 1998

What is the Women's Health and Cancer Rights Act of 1998?

The Women's Health and Cancer Rights Act of 1998 requires the Commonwealth to notify you, as a participant in the Public Employee Health Insurance Program, of your rights related to benefits provided through the program in connection with a mastectomy. The Women's Health and Cancer Rights Act is a federal law that provides protections to patients who choose to have breast reconstruction in connection with a mastectomy. Mastectomy, including reconstructive surgery, is covered the same as other surgery under your Plan option.

Following cancer surgery, the Plan covers:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Reconstruction of the other breast to achieve a symmetrical appearance;
- Prostheses and mastectomy bras; and
- Treatment of physical complications of mastectomy, including lymphedema.

For more detailed information on the mastectomy related benefits available under the plan, you should contact your carrier's Member Services unit or refer to your Certificate of Coverage.

Special Enrollment Rights

What are Special Enrollment Rights?

If you are declining enrollment for yourself, your spouse, and/or any of your eligible dependents because of other group health insurance coverage, you may be able to make a mid-year change to the Public Employee Health Insurance Program if the other group health coverage is lost. If other group health coverage is lost, you must request enrollment in the Public Employee Health Insurance Program no later than thirty (30) days of the loss.

In addition, if you acquire a new dependent as a result of marriage, birth, adoption, or placement for adoption, you

may be able to enroll yourself, spouse, and/or your dependents in the Public Employee Health Insurance Program provided that you request enrollment within thirty (30) days of the date of the event. You will have sixty (60) days from the date of birth to add newborns or adopted children. However, if you choose to add other eligible dependents at the same time as the newborn or adopted child, you must make the change no later than thirty (30) days.

HIPAA

What is HIPAA?

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

HIPAA and the Department for Employee Insurance

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

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

Insurance will only provide information pertaining to eligibility, enrollment, disenrollment and ***Qualifying Events***.

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

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

If you have any questions pertaining to HIPAA, please contact the Department for Employee Insurance.

HIPAA
Authorization Form

COBRA

What does COBRA stand for?

COBRA stands for the Consolidated Omnibus Budget Reconciliation Act of 1986.

What does COBRA do?

COBRA provides certain former employees, retirees, spouses, former spouses and dependent children the right to temporary continuation of health coverage at group rates. However, this coverage is only available when coverage is lost due to certain specific events, and the total cost of the policy, plus an administration fee, is paid by the person electing the continuation coverage.

How does a person become eligible for COBRA Continuation Coverage?

To be eligible for COBRA coverage, you must have been enrolled in your employer's health plan when you were employed and the health plan must continue to be in effect for active employees. COBRA continuation coverage is available upon the occurrence of a Qualifying Event that would, except for the COBRA continuation coverage, cause an individual to lose his or her health care coverage.

What is a Qualifying Event?

A Qualifying Event is an event that will cause the covered employee or the covered dependent(s) to lose coverage under the plan. These events are as follows:

- Termination of a covered employee's employment (other than for gross misconduct)
- A reduction in a covered employee's hours of employment
- The death of a covered employee
- A divorce or legal separation from the covered employee
- Ceasing to be a dependent child under the terms of the plan
- The covered employee becomes entitled to Medicare
- Employer bankruptcy (related only to retiree plans)

What is a Qualified Beneficiary?

A Qualified Beneficiary is an individual covered by a group health plan on the day before a Qualifying Event occurs.

How long after a Qualifying Event do I have to elect COBRA Continuation Coverage?

Qualified beneficiaries must be given an election period during which each qualified beneficiary may choose whether to elect COBRA continuation coverage. A covered employee or the covered employee's spouse may elect COBRA continuation coverage on behalf of all other qualified beneficiaries. A parent or legal guardian may elect on behalf of a minor child. Qualified beneficiaries must be given at least sixty (60) days for the election. This period is measured from the later of the coverage loss date or the date the COBRA Election Notice is provided. The Election Notice may be provided in person or by first class mail, but must be provided within fourteen (14) days after the plan administrator receives notice that a Qualifying Event has occurred.

Can individuals qualify for longer periods of COBRA continuation coverage?

Yes. Disability can extend the eighteen (18) month period of continuation coverage for a Qualifying Event that is a termination of employment or reduction of hours. To qualify for additional months of COBRA continuation coverage, the qualified beneficiary must:

- Have a ruling from the Social Security Administration that he or she became disabled within the first sixty (60) days of COBRA continuation coverage.
- Send the plan a copy of the Social Security ruling letter within sixty (60) days of receipt, but prior to expiration of the eighteen (18)-month period of coverage.

If these requirements are met, the entire family qualifies for an additional eleven (11) months of COBRA continuation coverage. Plans can charge 150% of the premium cost for the extended period of coverage.

When does COBRA Continuation Coverage begin?

COBRA continuation coverage begins on the date that health care coverage would otherwise have been lost by reason of a Qualifying Event.

If I elect COBRA, how much do I pay?

When you were an active employee, your employer may have paid all or part of your group health insurance premiums. Under COBRA, as a former employee no longer receiving benefits, you will usually pay the entire premium amount, which is the portion of the premium that you paid as an active employee and the amount of the employer contribution. In addition, there may be a two (2) percent administrative fee.

While COBRA rates may seem high, you will be paying group premium rates, which are usually lower than individual rates.

Since it is likely that there will be a lapse of a month or more between the date of layoff and the time you make the COBRA election decision, you may have to pay health premiums retroactively from the time of separation from the company. The first premium, for instance, will cover the entire time since your last day of employment with your former employer.

You should also be aware that it is your responsibility to pay for COBRA continuation coverage even if you do not receive a monthly statement.

Under COBRA, what benefits must be covered?

Qualified beneficiaries must be offered coverage identical to that available to similarly situated beneficiaries who are receiving coverage under the plan (generally, the same coverage that the qualified beneficiary had immediately before qualifying for continuation of coverage). A change in the benefits under the plan for the active employees will also apply to qualified beneficiaries. Qualified beneficiaries under the plan must be allowed to make the same choices given to non-COBRA beneficiaries under the plan, such as during periods of open enrollment by the plan.

Why should I elect COBRA?

One of the primary reasons people elect COBRA continuation coverage is to avoid breaks in coverage. A 63-day break in coverage may subject participants to a preexisting condition exclusion from future group health plans. If you have creditable coverage from another plan, then you can receive a reduction or elimination of these exclusionary periods. You should be provided a certificate of creditable coverage, free of charge, from your insurance carrier when you lose coverage under your plan, you become entitled to elect COBRA continuation coverage, your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your new plan's enrollment date.

How do I elect COBRA?

A qualified beneficiary should notify his/her insurance coordinator if a Qualifying Event occurs. The insurance coordinator will then send a Qualifying Event notification and an election form to employees and/or their covered dependents that are entitled to COBRA coverage. ***Please be advised that it is your responsibility to inform your insurance coordinator of any address change for you, your spouse, or your dependents so that COBRA information can be mailed to the current address***.

Where can I obtain additional information regarding COBRA?

Your first step for questions, election information and notification of Qualifying Event***s*** is to contact your agency's health insurance coordinator. Your insurance coordinator will be able to help you work through questions and start the COBRA continuation coverage process.

You can also contact the Department for Employee Insurance. The Department for Employee Insurance has COBRA specialists that can assist in difficult to administer areas of COBRA or assist in the COBRA process.

The Department for Employee Insurance also maintains current COBRA information on its Web site at http://personnel.ky.gov/dei.htm.

Initial COBRA Notice

At the time of employment, you should have received the following letter regarding your COBRA continuation rights.

General Notice of Right to Continuation of Group Health Insurance Coverage

Dear Member:

You are receiving this notice because you have become covered under a group health plan (the Plan). This notice contains vital information regarding you and your dependents' rights for continuation of group health insurance. This notice was designed to give you a summary of COBRA and what rights you and your dependents have upon your loss of group health coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). COBRA continuation coverage is available at your election when you would otherwise lose your group health coverage. It is also 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 contact the personnel representative at your agency of employment.

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". If coverage under the Plan is lost because of the Qualifying Event, then you, your spouse and your dependent children could become qualified beneficiaries. Under the Plan, qualified beneficiaries are responsible for payment of COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose coverage under the Plan because either one of the following Qualifying Events occurs:

- 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 occur:

- 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 enrolled in Medicare (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 occur:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than gross misconduct;
- The parent-employee becomes enrolled in Medicare (Part A, Part B or both);
- The parents becomes divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child".

When is COBRA Coverage Available?

Once the Plan Administrator has been notified that a Qualifying Event has occurred, then the Plan will offer COBRA continuation coverage to qualified beneficiaries. When the Qualifying Event is the end of employment or a reduction of hours of employment, death of the employee, or the employee becoming

entitled to Medicare benefits (under part A, Part B or both), the employer must notify the Plan Administer of the Qualifying Event.

You must Give Notice of Some Qualifying Events

For other Qualifying Events (divorce, legal separation of the employee and the spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Department for Employee Insurance within sixty (60) days after the Qualifying Event occurs. You must provide this to your Insurance Coordinator at your place of employment.

Length of COBRA Coverage Period

Listed below is the maximum period COBRA continuation coverage is available.

Qualifying Events that entitle you to COBRA continuation coverage	Length of COBRA continuation coverage
Termination of employee's employment (except for gross misconduct) (Former employee and covered dependents)	18 Months
Reduction of the employee's hours (Former employee and covered dependents)	18 Months
Death of a covered employee (Spouse and covered dependents)	36 Months
Divorce or legal separation from the covered employee (Spouse and covered dependents)	36 Months
Employee becomes entitled to Medicare (Part A, Part B or both) (Spouse and covered dependents)	36 Months
Dependent child covered under plan ceases to be an eligible dependent under the plan	36 Months
Person considered to have total disability, according to the Social Security Administration	29 Months

What events permit an extension of COBRA Continuation Coverage?

COBRA continuation coverage can be extended in one of two ways, which provides an extended period of time for certain Qualifying Events. Listed below are the two ways in which COBRA continuation coverage may be extended. Both require the covered employee to have incurred the first Qualifying Event of termination of the covered employee's employment or reduction of a covered employee's hours.

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 the Department for Employee Insurance and your Carrier in a timely fashion, you and your entire family may be entitled to receive up to an additional eleven (11) months of COBRA continuation coverage, for a total maximum of twenty-nine (29) months. The disability must begin before the sixtieth (60th) day of COBRA continuation coverage and must last at least until the end of the eighteenth (18th) month period of continuation coverage.

Second Qualifying Event extension of 18-month period of continuation coverage

If your family experiences another Qualifying Event while receiving eighteen (18) months of COBRA continuation coverage, the spouse and dependent children can get an extension of up to eighteen (18) months of COBRA continuation coverage, for a maximum of thirty-six (36) months. This extension may

be available to the spouse and any dependent children receiving continuation coverage if the Department of Employee Insurance and the Carrier are timely notified of the Qualifying Event. The chart below describes the events that qualify as a second Qualifying Event and the length of the extension permitted.

Second Qualifying Event	**Length of Extension /Total Coverage Period**
Former Employee Dies	18 Months / 36 Months Maximum
Entitlement of Medicare (Parts A or B or Both)	18 Months / 36 Months
Divorce or Legal Separation	18 Months / 36 Months
Dependent Child ceases to be eligible under the Plan	18 Months / 36 Months

COBRA continuation coverage expressly requires that the first event be either termination of a covered employee's employment or reduction of a covered employee's hours.

If you have any question

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to your insurance coordinator or the Department for Employee Insurance identified below. For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, you may 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.

Keep your address current

In order to protect you family's rights, you should keep the Employer (Insurance Coordinator) informed of any address changes for you or your covered dependents. You should also keep a copy of any notices you send to the Plan Administrator for your records.

Plan Contact Information

The Plan Administrator is the Department for Employee Insurance, 200 Fair Oaks Lane, 5th Floor Suite 501, Frankfort, Kentucky 40601, 502-564-6534. If additional information is needed, or you lose group health coverage, contact the above-referenced office for any comments or concerns regarding COBRA rights.

FLEXIBLE SPENDING ACCOUNTS

What is a Flexible Spending Account?

A Flexible Spending Account is a pre-tax account that saves you money on covered medical expenses and dependent care expenses. You may enroll in one or more Flexible Spending Accounts offered by your employer. You may contribute specified amounts from your salary toward a Health Care Flexible Spending Account and/or a Dependent Care Account. Contact your agency's health insurance coordinator for specific information.

Will my employer contribute any money to a Flexible Spending Account?

The Commonwealth will contribute a set dollar amount toward your health insurance each month. If you elect to waive your health insurance coverage, the Commonwealth will contribute $234 each month into a Health Care Flexible Spending Account. You must complete an application for the Flexible Spending Account Program (in addition to the Health Insurance Application). For state agency employees, the Flexible Spending Account application has been combined with the health insurance application. **Enrollment is not automatic. You must complete a new application each year.**

- **State Agency Employees** – You are eligible for the Commonwealth Choice Flexible Spending Account Program. Contact your Health agency's health insurance coordinator for an enrollment form and handbook.

- **School Board Employees, Health Department Employees, KCTCS employees and members of other groups participating in the Program,** you may be eligible for a Flexible Spending Account Program. To find out if a Flexible Spending Account Program is available to you, contact your agency's health insurance coordinator.

Retirees are not eligible for participation in the Flexible Spending Account Program.

Minimum and Maximum contribution amounts

The minimum combined contribution (employer/employee) is $5 per pay period for either the Health Care Flexible Spending Account or the Dependent Care Account.

The maximum combined contribution (employer/employee) is $120 per pay period for the Health Care Flexible Spending Account. The maximum yearly contribution for

Dependent Care Account depends on your tax filing status. Refer to your FSA Handbook for additional information.

Employer contributions cannot be directed into a Dependent Care Account.

FREQUENTLY ASKED QUESTIONS

Who do I contact to make changes to my existing health insurance coverage?

Contact your agency's health insurance coordinator, or your retirement system for any information regarding a change in your existing health insurance coverage. In order to qualify to make any changes after Open Enrollment, you must experience an eligible ***Qualifying Event***.

Will my newborn automatically be enrolled?

Enrollment for your newborn is NOT automatic.

If you plan to only add the newborn child, the application must be completed and signed no later than sixty (60) days of the birth or adoption of the child.

If you plan to exercise the Special Enrollment Rights pursuant to HIPAA and add other eligible dependents at the same time as a newborn or newly adopted child, the application must be completed and signed within thirty (30) days of the birth or adoption and the effective date of these dependents will be the same as that of the newborn or adopted child.

Will I get a new health insurance identification card every plan year?

Every employee will receive a new identification card for 2005.

If you lose your identification card, you may request a replacement card from your health insurance carrier at any time during the year.

What should I do if my address changes?

Any time your home address changes you must contact your agency's health insurance coordinator and complete a health insurance Update Form. This Update Form will be forwarded to the Department for Employee Insurance for processing and your health insurance carrier will be notified.

What happens when a dependent child turns 24 years of age?

A dependent child may be covered on your Parent Plus or Family plan up to the age of 24 (end of the month in which he/she turns 24) regardless of student status, and as long as the child meets the dependent requirements. Your dependent over age 24 will be automatically removed from your plan at the end of the month in which he/she turns 24. If removing your dependent from your plan will change your level of coverage, the system will automatically change your level to the following:

- A Parent Plus plan will change to a Single plan.
- A Family plan will change to a Couple plan.

Your over age dependent child may continue on the Public Employee Health Insurance Program through COBRA. You should contact your agency's health insurance coordinator to confirm eligibility.

As a retiree, may I participate in one of the FSA Programs?

No. Retirees are not eligible to participate in the FSA Programs.

TERMS YOU NEED TO KNOW

Balance Billing	If you use ***out-of-network*** benefits, you may be "balance billed" for any amount not paid by your insurance carrier. This means the provider (doctor, hospital, etc.) may bill you for the amount that your insurance carrier did not pay, in addition to the amount of your co-insurance. Your carrier's payment is made based on a fee schedule that would normally be used in Kentucky.
Co-insurance	A percentage of the charges that you are responsible to pay to the doctor, hospital, pharmacy, or other provider. This percentage may vary based on the services provided.
Deductible	The initial amount of medical or hospital expenses you must pay before your insurance carrier 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 carrier. The term "eligible expense" and "reasonable and customary charge" may be interchangeable.
Emergency Medical Condition	A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson would reasonably have cause to believe constitutes a condition: (1) placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part. With respect to a pregnant woman who is having contractions, an **emergency medical condition** is: (1) a situation in which there is inadequate time to effect a safe transfer to another hospital before delivery; or (2) a situation in which transfer may pose a threat to the health or safety of the woman or the unborn child.

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 each carrier. Formularies may differ among carriers.
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 health insurance carrier to provide services for members covered under that particular health plan.
In-patient Care	Care delivered to a patient who is officially admitted and occupies a hospital bed while receiving hospital care.
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.
Out-of-network	Physician, pharmacies, hospitals, and other providers who do not have contracts with a particular health insurance carrier to provide services.
Pre-certification	Prior approval required for non-emergency medical and surgical hospital admissions. Your health insurance carrier determines the diagnostic need for certain surgical and diagnostic procedures and approves appropriate lengths of stay for admissions.
Qualifying Event	An event that may allow an employee/retiree to make a mid-year election change in their health insurance or, in some cases, their FSA. The change must be on account of and consistent with the ***Qualifying Event***.
Urgent Care	Medical care that is appropriate to the treatment of a non-life threatening illness or injury, but requires prompt medical attention.
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 carrier.

The Advantages of Blue.

Large PPO physician network –
Convenient access to more than 9,500 physicians in Kentucky[1]

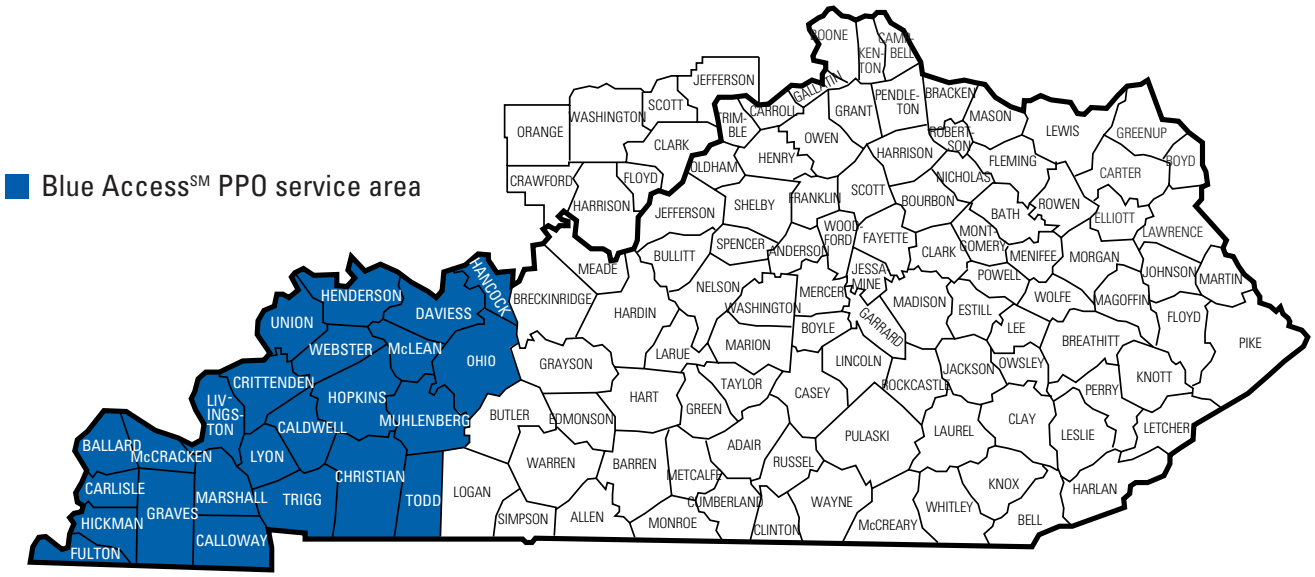
Coverage while traveling –
Our BlueCard® program connects members to health care providers when members are traveling outside of their Plan's service area. Members should not have to complete any claim forms and in most cases, members are not balance billed after the payment is made as long as the member uses a BlueCard PPO provider.

Large pharmacy network –
Access to nearly 50,000 independent and chain pharmacies

Anthem.com –
24-hour access to online provider directories, extensive health resources and discounts on health-related services and products.

Enjoy the strength and security of coverage from one of the largest, most experienced health benefits organizations in the nation.[2]

Anthem proudly serves Commonwealth of Kentucky employees in the shaded counties below:



Visit www.anthem.com or call toll free (888) 650-4047 for questions or to learn more about Anthem.

Anthem®

Note: Some services may not be covered under your health plan. Please refer to your benefit plan certificate for details concerning benefits, limitations and exclusions.

1 Anthem data as of Spring 2002. 2 Blue Cross Blue Shield Association, **Brand Talk**.

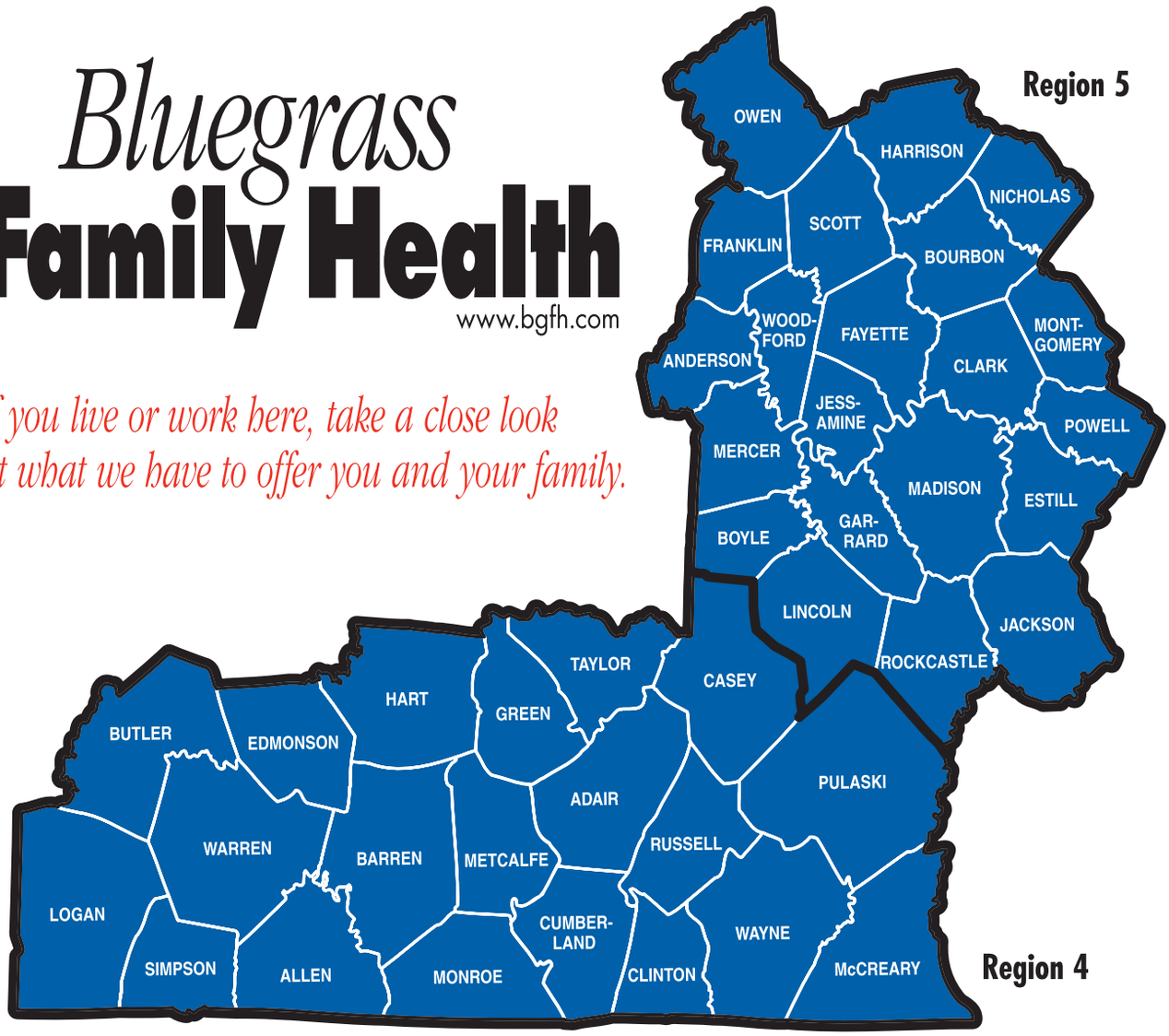
Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Kentucky, Inc. An independent licensee of the Blue Cross and Blue Shield Association. ® Registered marks Blue Cross and Blue Shield Association.

AHP 1059 (01/05)

Bluegrass Family Health

www.bgfth.com

If you live or work here, take a close look at what we have to offer you and your family.



- Kentucky-based company offering health insurance to Commonwealth of Kentucky employees for over 10 years
- Not-for-profit health plan
- Our focus is our members, and we have survey results showing that Bluegrass Family Health provides exceptional customer service
- Take advantage of what Bluegrass Family Health has to offer for your entire family
- An extensive provider network
- Emergency service provisions while you are traveling

Visit us online at:

www.bgfth.com

Click on our State Open Enrollment icon for information about Bluegrass Family Health.

Bluegrass Family Health

Lexington
651 Perimeter Drive, Suite 300
Lexington, KY 40517

859-269-4475
800-787-2680

Louisville
9750 Ormsby Station Road, Suite 110
Louisville, KY 40223

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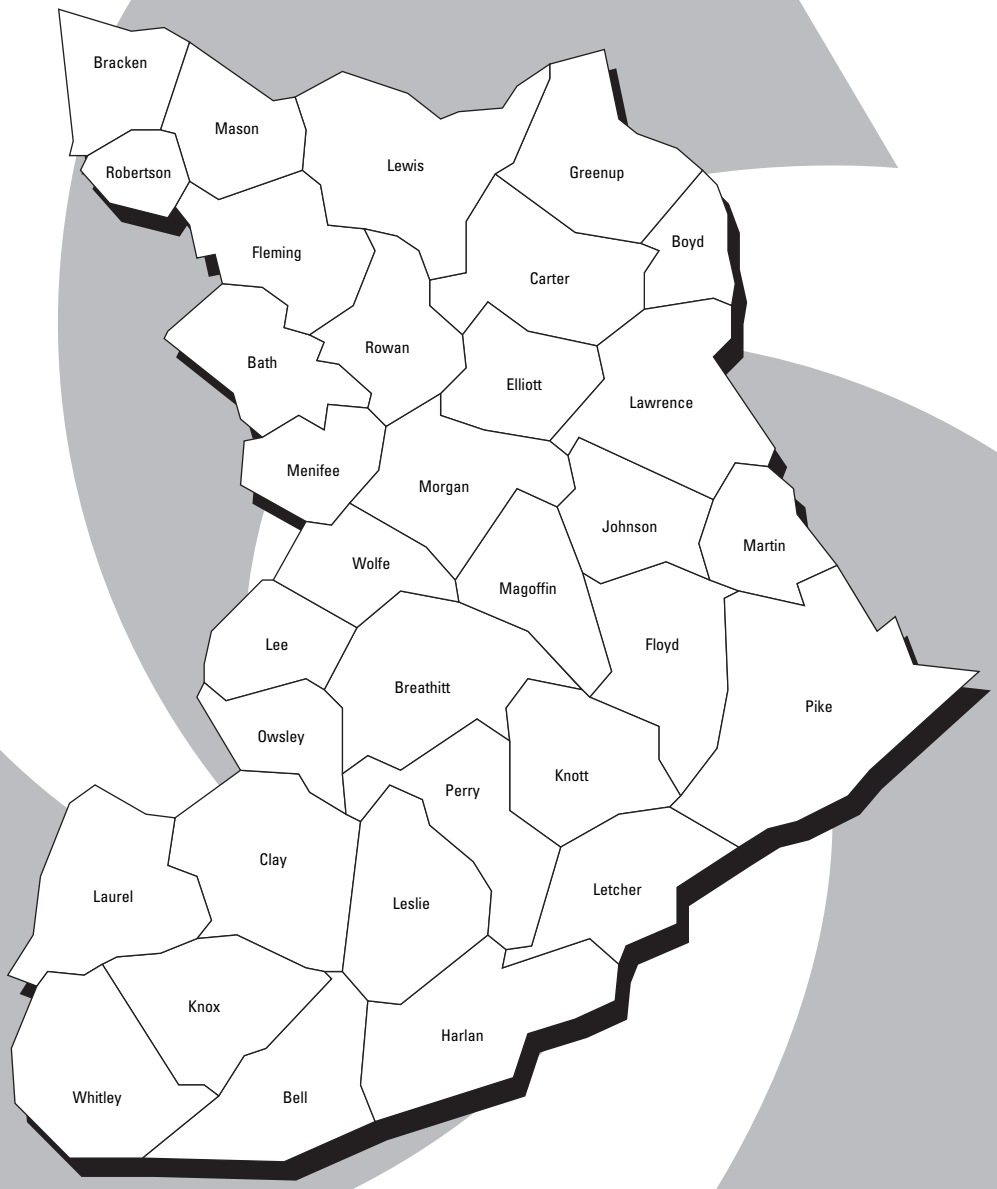
CHA Health Service Area



CHA HEALTH®

Visit www.cha-state-enrollment.com or call toll free 800-840-3885 for more information.

Why UnitedHealthcare?

It just makes sense for you and your family.

We put you first.

For too many years, the health care industry has created policies and procedures according to what works for them. UnitedHealthcare's approach is about what works for you and your family. **It just makes sense.**

We offer a unique approach to health care coverage.

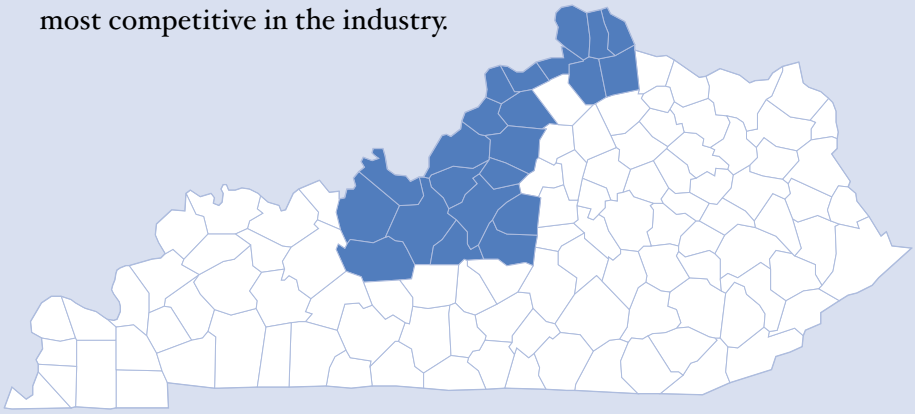
Our Care Coordination℠ program keeps medical decision-making where it belongs – between you and your doctors.

We make it easy for you.

With UnitedHealthcare, you don't need a written referral to see a specialist. And through our consumer Web site, myuhc.com, you have round-the-clock access to information and services. You can print temporary ID cards, order new ID cards, search our extensive network or check the status of your claims, all online!

We offer you access to broad networks of physicians and hospitals.

UnitedHealthcare's philosophy is to offer a broad network of high-quality, cost-effective physicians and health care providers. We have 420,000 physicians and 3,500 hospitals in our network across the country. Our local and national provider contracts are some of the most competitive in the industry.



UnitedHealthcare's Service Area

We provide tools to help you make good health care decisions.

myuhc.com, your customized Web site, allows you to take a personal Health Assessment, research medical conditions with the latest information, evaluate treatment options and estimate the costs of different treatment options.

We offer programs to help keep you healthy.

UnitedHealthcare works to improve the health and well-being of those with chronic conditions, such as asthma and diabetes, through education, outreach and lifestyle counseling.

We're strong, stable and committed to Kentucky.

UnitedHealthcare provides health benefits to over 200,000 individuals in the state of Kentucky alone. Across the country, we provide services to over 18 million Americans. Fortune magazine has ranked UnitedHealth Group the first or second "most admired health care company in America" every year since 1994.

If you have questions during Open Enrollment

(through December 31, 2004)

- Call our special 2004 Open Enrollment Line, toll-free, at **1-866-873-3903** — select Prompt #1
- Search for a network provider online at **www.provider.uhc.com/commonwealth**

If you have questions starting January 1, 2004 after you enroll with UnitedHealthcare

- Call Customer Service, toll-free, at the number on the back of your ID card
- Check out your member Web site, **myuhc.com**

UnitedHealthcare®

It just makes sense.℠

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PHONE NUMBERS AND WEB SITES

Personnel Cabinet
Department for Employee Insurance
Member Services Branch
(888) 581-8834
(502) 564-6534
http://personnel.ky.gov/dei.htm

Kentucky Retirement Systems
(800) 928-4646
(502) 564-4646 ext. 4520
www.kyret.com

Kentucky Teachers' Retirement System
(800) 618-1687
(502) 848-8500
http://ktrs.ky.gov/medical.htm

Judicial/Legislators Retirement Plans
(502) 564-5310

Anthem Blue Cross Blue Shield
(888) 650-4047
www.anthem.com

Bluegrass Family Health
(800) 787-2680
(859) 269-4475
www.bgfh.com

CHA Health
(800) 840-3885
(859) 232-8686
www.cha-health.com

United Healthcare
(866) 288-6684 (Operational as of 1/1/2005)
www.uhc.com

This Handbook was prepared by:

The Staff of the
Kentucky Personnel Cabinet
Department for Employee Insurance

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This Handbook is available in an accessible format upon request and is available on the Internet at:

http://personnel.ky.gov/dei.htm

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