KENTUCKY EMPLOYEES' HEALTH PLAN

SUMMARY PLAN DESCRIPTION

For the

COMMONWEALTH STANDARD PPO MEDICAL PLAN

Sponsored by

Commonwealth of Kentucky

Group Number(s): P5941, P6070 and P6077

Plan and Option Number(s): 99/001

Effective: January 1, 2012

GRANDFATHER CLAUSE

This group health plan believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that *your* Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the *Plan Administrator* at:

Commonwealth of Kentucky
Executive Director, Office of Legal Services
501 High Street
Third Floor
Frankfort, KY 40601

You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

YOUR RIGHTS AND RESPONSIBILITIES

As a Humana *plan member*, *you* have the right to:	***You* also have the responsibility to:**
• Be provided with information about the Humana *plan*, its *services* and benefits, its *providers*, and *your member* rights and responsibilities. • Privacy and confidentiality regarding *your* medical care and records. Records pertaining to *your* health care will not be released without *your* or *your* authorized representative's written permission, except as required by law. • Discuss *your* medical record with *your physician*, and receive upon request a copy of that record. • Be informed of *your* diagnosis, treatment choices, including non-treatment, and prognosis in terms *you* can reasonably expect to understand, and to participate in decision-making about *your* health care and treatment plan. • Have a candid discussion with *your* practitioner about appropriate or *medically necessary* treatment options for *your* conditions, regardless of cost or benefit coverage. • Expect reasonable access to *medically necessary* health care *services* regardless of race, national origin, religion, physical abilities, or source of payment. • File a formal complaint, as outlined in the *plan's* grievance procedure, and to expect a response to that complaint within a reasonable period of time. • Be treated with courtesy and respect, with appreciation for *your* dignity and protection of *your* right to privacy. • Make recommendations regarding the *Plan's* "rights and responsibilities" policies.	• Give the Humana *Plan* and *your* health care *provider* complete and accurate information needed in order to care for *you*. • Read and be aware of all material distributed by the *plan* explaining policies and procedures regarding *services* and benefits. • Obtain and carefully consider all information *you* may need or desire in order to give informed consent for a procedure or treatment. • Follow the treatment plan agreed on with *your* health care *provider*, and to weigh the potential consequences of any refusal to observe those instructions or recommendations. • Be considerate and cooperative in dealing with the *plan providers* and to respect the rights of fellow *plan members*. • Schedule appointments, arrive on time for scheduled visits, and notify *your* health care *provider* if *you* must cancel or be late for a scheduled appointment. • Express opinions, concerns, or complaints in a constructive manner. • Notify the *Plan Sponsor* (Commonwealth of Kentucky) in writing if *you* move or change *your* address or phone number, even if these changes are only temporary. • Pay all *copayments*, *coinsurance* and/or *premiums* by the date when they are due. • Be honest and open with *your physician* and report unexpected changes in *your* condition in a timely fashion. • Follow health care facility rules and regulations affecting patient care and conduct.

As a Humana *plan member*, *you* have the right to:	***You* also have the responsibility to:**
• Receive Humana's Notice of Privacy Practices. • Expect *your* personal information to be kept secure and used appropriately for payment and health plan operations. • Expect Humana to adhere to all privacy and confidentiality policies and procedures. • Expect the following activities concerning *your* personal information: ➢ Request an accounting of disclosures of personal health information disclosed for reasons outside of payment and health plan operations. ➢ Receive an authorization form for any proposed use of *your* personal health information outside of routine payment and health plan operations. ➢ Request an alternate form of communication of personal health information if the release of a portion or all of the information could endanger life or health. ➢ Right to complain regarding an alleged breach of privacy. ➢ Right to agree or object regarding Humana's intent to release *your* personal information outside of payment or health plan operations. ➢ Right to request an amendment or correction of *your* personal information to a designated record created by Humana. ➢ Right to request access to inspect and copy information.	• Carry *your* Humana identification card with *you* at all times and use it while enrolled in the Humana *Plan*.

As a Humana *plan member, you* have the right to: • Expect the following activities concerning *your* personal information continued: ➢ Right to request Humana to restrict the use and disclosure of *your* personal information and the right to terminate the restriction request.	

INTRODUCTION

THE SUMMARY PLAN DESCRIPTION (SPD) – YOUR HEALTH CARE PLAN GUIDE

Welcome to *your* DEI-sponsored health care *plan* (KEHP) administered by Humana Insurance Company (Humana). DEI has provided *you* with this *Summary Plan Description* (*SPD*), which outlines *your* benefits, as well as *your* rights and responsibilities under this *Plan*.

This *SPD* is *your* guide to the benefits, provisions and programs offered by this *Plan*. *Services* are subject to all provisions of this *Plan*, including the limitations and exclusions. Please read this *SPD* carefully, paying special attention to the "Schedule of Benefits", "Medical Covered Expenses", and "Limitations and Exclusions" sections to better understand how *your* benefits work. If *you* are unable to find the information *you* need, please contact Humana at the toll-free customer service number on *your* Humana Identification (ID) card or visit our website at www.humana.com.

This *SPD* presents an overview of *your* benefits. In the event of any discrepancy between this *SPD* and the official Plan Document, the Plan Document shall govern.

DEFINED TERMS

Italicized terms throughout this *SPD* are defined in the Definitions section. An italicized word may have a different meaning in the context of this *SPD* than it does in general usage. Referring to the Definitions section as *you* read through this document will help *you* have a clearer understanding of this *SPD*.

PRIVACY

Humana understands the importance of keeping *your protected health information* private. *Protected health information* includes both medical information and individually identifiable information, such as *your* name, address, telephone number or Social Security number. Humana is required by applicable federal law to maintain the privacy of *your protected health information*.

CONTACT INFORMATION

Customer Service Telephone Number:

Please refer to *your* Humana ID card for the applicable phone number.

Claims Submittal Address:

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

Claims Appeal Address:

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

TABLE OF CONTENTS

Page Number

SECTION 1, HEALTH RESOURCES AND PRECERTIFICATION 8
HEALTH RESOURCES 9
PRECERTIFICATION 16
PREDETERMINATION OF BENEFITS 16
SECTION 2, MEDICAL BENEFITS 17
UNDERSTANDING YOUR COVERAGE 18
SCHEDULE OF BENEFITS 20
MEDICAL COVERED EXPENSES 48
LIMITATIONS AND EXCLUSIONS 66
COORDINATION OF BENEFITS 75
CLAIM PROCEDURES 78
SECTION 3, ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE 87
TERMINATION OF COVERAGE 97
SECTION 4, GENERAL PROVISIONS AND REIMBURSEMENT/SUBROGATION 98
GENERAL PROVISIONS 99
REIMBURSEMENT/SUBROGATION 101
SECTION 5, NOTICES 105
IMPORTANT NOTICE FOR EMPLOYEES AND SPOUSES AGE 65 AND OVER 106
PRIVACY OF PROTECTED HEALTH INFORMATION 108
CONTINUATION OF MEDICAL BENEFITS (COBRA) 110
THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF. 116
1994 (USERRA) 116
MEDICAL CONVERSION PRIVILEGE 117
ADDITIONAL NOTICES 118
MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) 120
PLAN DESCRIPTION INFORMATION 125
SECTION 6, DEFINITIONS 127
SECTION 7, ADDITIONAL NOTICES 151
NOTICE TO ENROLLEES CONCERNING TOBACCO 152
NOTICE OF PRIVACY PRACTICES (SUMMARY) 152
APPENDIX A 159
APPENDIX B 161

SECTION 1

HEALTH RESOURCES AND PRECERTIFICATION

HEALTH RESOURCES

Health Resources is a comprehensive set of clinical programs and services available to help *covered persons* better understand their health care benefits and how to use them, navigate the health care system when they need it, understand treatment options and choices, reduce their costs and enhance the quality of life.

Each Health Resources program is tailored to meet different health care needs, from those that want to stay well when they are healthy, to those that are at risk for an illness, to those who are at chronic or acute stages of illness. Health Resources offer a wide range of assistance including online educational tools, interventions, health assessments and personal discussions with registered nurses.

Below is a brief description of this *Plan's* Health Resources programs. For additional information or questions regarding any of these programs, please contact the customer service telephone number on the back of *your* ID card.

*MY*HUMANA

*My*Humana is a personal, password-protected home page that provides information and tools to help *covered persons* make informed decisions. Go to www.humana.com and click on "log in or register" to receive step by step instructions on how to set up *your* page. After *you* have set up *your* page, log on anytime to find a *participating provider*, look up benefits or check the status of a *claim*. *You* can also find shop-and-compare tools to help *you* choose *hospitals* and doctors, a health encyclopedia, information on specific health conditions, financial tools to help with budgeting for health care and more.

TRANSPLANT MANAGEMENT

The Transplant Management team provides hands-on support to *covered persons* in need of organ and tissue transplants. They guide *covered persons* to Humana's National Transplant Network (NTN), designed to control costs and deliver a superior transplant experience. They review coverage, coordinate benefits, facilitate services and follow the transplant recipient's progress from initial referral through treatment and recovery.

TRANSITION OF CARE

Changing health care plans can be stressful, especially for those who are going through intense medical treatment, such as chemotherapy. Humana understands this and does not want to hinder progress or interfere with the doctor-patient relationship. The transition of care process helps *covered persons* make a smooth transition to Humana from their current health care plan with the least amount of disruption to their care.

CONTINUITY OF CARE

If *your* provider ceases being a *PAR provider you* may be able to continue treatment with the same provider for up to 90 calendar days if *you* are undergoing active treatment for a chronic or acute medical condition after the *PAR provider's* termination with the *PAR provider's* network. For pregnancy, if *you* are in the 2nd or 3rd trimester, continuity of care is available through a 6 week postpartum period. Continuity of care is available only if the provider continues to practice in the geographical area of the network and the termination of the *PAR provider's* contract was not due to misconduct on the part of the provider.

NURSE LINE

Nurse Advice Line is a toll-free, 24-hour medical information line, (1-800-622-9529) staffed by Registered Nurses who are available to answer *your* health-related questions and help *you* decide where to best seek treatment. The Nurse Line helps *you* in two ways:

Immediate Medical Concerns: Registered nurses can be of service when *you* are thinking about taking *your* child to the *hospital* for a fever in the middle of the night or deciding if a reaction to a new medication is normal. They can also help with "how-to" questions, like how to change a bandage or how to prepare for lab tests.

Health Planning and Support: When planning a future medical procedure, Registered Nurses offer guidance in understanding *your* options, choosing *providers* and using *your* health benefits wisely. When additional clinical support is needed, these nurses will connect *you* with specialty programs to address *your* unique needs.

INFORMED CARE MANAGEMENT

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

This *Plan's* disease management programs include:

- **Asthma**: This program provides participants with education to help them better understand their disease and to take a more active role in controlling it. The program helps participants adhere to the treatment plan prescribed by their physician, helps them increase their self-monitoring skills and promotes compliance with controller medications.

- **Cancer (active treatment only)**: The cancer management program offers support and educational services to adults with cancer who have begun or are planning to undergo *surgery*, chemotherapy, radiation therapy or biological therapy, those that have a history of cancer that has recurred and those that have declined further therapy but require supportive management. The program's oncology care managers have an average of 10 years of professional experience in understanding cancer, its symptoms, side effects and treatments.

- **Chronic Kidney Disease (CKD)**: The CKD program focuses on high quality care and education on available treatment options, prevention and management of associated complications and the progression of renal disease. Health Service Coordinators, field-based, experienced nephrology nurses, guide participants through a 5-step process during the course of their treatment that includes a personal assessment of the patient's needs, a care plan developed with the patient's doctor, a nephrology referral, if necessary, a collection of clinical indicators and quarterly reports of outcomes.

- **Congestive Heart Failure**: This program focuses on those with moderate to severe heart failure and is delivered primarily through critical care nurses who assist participants through a combination of intervention, monitoring and education.

- **Coronary Artery Disease**: This program helps participants adhere to their physicians' prescription and treatment plan, monitor their health status for complications and decrease cardiovascular risks. Ongoing guidance and education is provided, focusing on clinical and behavioral issues such as high blood pressure, elevated lipid levels, smoking and lack of exercise. Specialized cardiac nurses are available to discuss issues and answer questions.

- **Diabetes:** This program provides ongoing education about disease management and monitoring in the areas of diet, exercise and lifestyle. Registered nurses who have received additional training in diabetes disease management are available to answer questions.

- **End Stage Renal Disease (ESRD)**: The end-stage renal disease program provides case management designed to address quality-of-life issues of those with this condition. ESRD staff work closely with participants, local nephrologists and dialysis centers to coordinate services and monitor medical management.

- **Rare Diseases (Amyotrophic Lateral Sclerosis, or Lou Gehrig's Disease; Chronic Inflammatory Demyelinating Polyradiculoneuropathy Disease (CIDP); Cystic Fibrosis; Dermatomyositis; Hemophilia; Multiple Sclerosis; Myasthenia Gravis; Parkinson's Disease; Polymyositis; Rheumatoid Arthritis; Scleroderma; Sickle Cell Disease; and Systemic Lupus)**: Through specific programs for each disease, participants receive information tailored to their individual situation. Each program addresses the individual's medical, educational and psychological needs by providing disease-specific online tools and resources, service coordination and education via telephone contact and access to specially trained nurses.

- **Neonatal Intensive Care**: This program combines care coordination and parent education to help improve the patient's outcome and reduce stress on the family.

- **Cerebrovascular/Stroke; Hypertension; Peripheral Artery Disease; Chronic Obstructive Pulmonary Disease (COPD); Osteoporosis Primary and Secondary; Gastroesophageal Reflux Disease (GERD); Peptic Ulcer Disease; Inflammatory Bowel Disease (IBD)/Crohn's; Chronic Hepatitis; Geriatrics; Seizure Disorders; Migraine; Hypercoagulable State; Oncology; HIV Support; Low Back Pain**: These programs are designed to educate *you* and coordinate the multiple facets of *your* care.

- **Why Weight Kentucky:** This program is designed to assist *you* in achieving and maintaining a healthy weight. *Members* will be identified as potential candidates for the program through self-referral, Personal Health Analysis and claims data. In order to participate in this program *you* must have a BMI equal to or greater than 30.

RADIOLOGY REVIEW SERVICES

Radiology Review Services is a service that offers convenient scheduling of imaging procedures (CT, CTA, MRI, MRA and PET scans). Radiology Review Services is designed to help avoid issues such as inappropriate or unnecessary imaging studies that are costly and inconvenient to the patient, by educating ordering physicians on imaging procedures and best practice guidelines before the procedure is scheduled. Physicians may now call Humana to initiate the consultation and schedule any imaging procedure for a Humana *member*.

CAREENGINE℠ SERVICE

The CareEngine℠ Service provided through ActiveHealth Management, Inc., combines a clinical search engine with expert medical opinions to uncover and address potential medical errors and instances of sub-optimal medical treatment.

The CareEngine℠ applies a wide range (over 1,500 categories) of clinical rules to patient pharmacy, laboratory and claims data to identify patients at risk of highly specific patient-centric problems, such as misdiagnoses, flawed surgical treatment or medical management and lack of follow-up care or preventive treatment. It also identifies a variety of pharmacy issues such as drug-to-drug interactions, drug-to-disease interactions, and drug-to-metabolic interactions.

The CareEngine℠ clinical rules address both "high-impact" clinical issues and wellness/prevention issues. Wellness/prevention issues include recommended health screenings such as mammograms, osteoporosis screening in women over age 65, scans, blood lead screening in young children, diabetic eye exams, immunizations, etc. The CareEngine℠ Service then generates patient-specific care improvement recommendations, reflecting the latest evidence-based standards of clinical excellence, which are then communicated to treating physicians in time to effect significant improvements in clinical outcomes.

TELEPHONIC HEALTH COACHING AND WEB PROGRAM

Covered persons can elect to receive a series of telephone calls from *behavioral health* specialists, health educator coaches or registered nurses regarding six main wellness topics including: physical activity, nutrition, stress management, weight management, back care and tobacco cessation. *Covered persons* can also reach out to their “coach” as often as needed.

Offered in conjunction with Health Coaching, *covered persons* will receive tailored communication based upon a confidential topic assessment, including a written personalized action plan and a series of newsletters.

VITALITY REWARDS PROGRAM

From time to time Humana may enter into agreements with third parties who administer Rewards programs that may be available to *you*. Through these programs, *you* may earn rewards by:

- Completing certain activities such as wellness, educational, or informational programs; or
- Reaching certain goals such as lowering blood pressure or becoming smoke free.

The rewards may include non-health plan benefits such as merchandise, gift cards, debit cards, discounts or contributions to *your* health spending account. Humana is not responsible for any rewards that are non-health plan benefits or for *your* receipt of such reward.

The rewards may also include health plan benefits such as a reduction in *copayments*, *deductibles* or *coinsurance*, as permitted under applicable state and federal laws.

The rewards may be taxable income. *You* may consult a tax advisor for further guidance.

Humana's agreement with any third party does not eliminate any of *your* obligations under this Plan or change any of the terms of this Plan. Humana's agreement with the third parties and the program may be terminated at any time.

Please call the telephone number listed on *your* identification card or in the marketing literature issued by the Rewards program administrator for a possible alternative activity if:

- It is unreasonably difficult for *you* to reach certain goals due to *your* medical condition; or
- *Your qualified practitioner* advises *you* not to take part in the activities needed to reach certain goals.

The Rewards program administrator or Humana may require proof in writing from *your qualified practitioner* that *your* medical condition prevents *you* from taking part in the available activities.

The decision to participate in these programs or activities is voluntary and *you* may decide to participate anytime during the *year*. Refer to the marketing literature issued by the Rewards program administrator for their program's eligibility, rules and limitations.

Participation in Humana Vitality Program may include physical exercise, biometric testing and other health and fitness activities. These activities may involve risks and may not be appropriate for all persons. Humana Vitality Program Participants fully accept all risk and responsibility involved in engaging in Humana Vitality services. Humana is not liable for any loss, injury, or other adverse events in connection with participation in the Humana Vitality Program. Before taking part in these tests or activities, Participants should consult with their healthcare professional for a thorough evaluation and review of their present condition, and guidance in what tests and activities are safe and appropriate. If it is unreasonably difficult due to a medical condition for a Participant to achieve the standards for the rewards under this program, or if it is medically inadvisable for them to attempt to achieve the standards for the rewards under this program, they can call the number on the back of their Humana Vitality member identification (ID) card and Humana will work with them to develop another way to qualify for the reward.

UTILIZATION MANAGEMENT

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

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

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

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

PRECERTIFICATION

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

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

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

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

1 Advise *you* in writing if the proposed treatment plan is *medically necessary*;

2. Advise *you* in writing the number of days the *confinement* is initially *precertified*; and

3. Conduct *concurrent review* as necessary.

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

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

Penalty for Not Obtaining Precertification

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

PRECERTIFICATION

There are certain *services* that may require *precertification*. Please contact your *qualified practitioner* or Humana before *services* are performed. It is recommended that *you* call the toll-free customer service phone number on the back of *your* ID card as soon as possible to receive proper *precertification*.

PREDETERMINATION OF BENEFITS

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

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

SECTION 2

MEDICAL BENEFITS

PARTICIPATING AND NON-PARTICIPATING PROVIDERS

This *Plan* has two (2) levels of benefits – *participating provider (PAR provider)* benefits and *non-participating provider (Non-PAR provider)* benefits, payable as shown in the Schedule of Benefits section. *You* may select any *provider* to provide *your* medical care.

In most cases, if *you* receive *services* from a *PAR provider*, this *Plan* will pay a higher percentage of benefits and *you* will have lower out-of-pocket costs. *You* are responsible for any applicable *deductibles*, *coinsurance* amounts and/or *copayments*.

If *you* receive *services* from a *Non-PAR provider*, this *Plan* will pay benefits at a lower percentage and *you* will pay a larger share of the costs. Since *Non-PAR providers* do not have contractual arrangements with Humana to accept discounted or negotiated fees, they may bill *you* for charges in excess of the *maximum allowable fee*. *You* are responsible for charges in excess of the *maximum allowable fee* in addition to any applicable *deductibles*, *coinsurance* amounts and/or *copayments*. Any amount *you* pay to the *provider* in excess of *your coinsurance* or *copayment* will not apply to *your out-of-pocket limit* or *deductible*.

Not all *qualified practitioners* including pathologists, radiologists, anesthesiologists, and emergency room physicians who provide *services* at *PAR hospitals* are *PAR qualified practitioners*. If *services* are provided to *you* by such facility based *Non-PAR qualified practitioners* at a *PAR hospital*, this *Plan* will pay for those *services* at the *PAR provider* benefit percentage. Facility based *Non-PAR qualified practitioners* may require payment from *you* for any amount not paid by this *Plan*. If possible, *you* may want to verify whether *services* are available from a *PAR qualified practitioner*.

In the event that a specific medical *service* cannot be provided by or through a *PAR provider*, a *covered person* is entitled to coverage for *medically necessary covered expenses* obtained through a *Non-PAR provider* when approved by this *Plan* on a case by case basis.

PAR PROVIDER DIRECTORY

DEI will automatically provide, without charge, information to *you* about how *you* can access a directory of *PAR providers* appropriate to *your* service area. An online directory of *PAR providers* is available to *you* and accessible via Humana's website at www.humana.com. This directory is subject to change. Due to the possibility of *PAR providers* changing status, please check the online directory of *PAR providers* prior to obtaining *services*. If *you* do not have access to the online directory, contact Humana at the customer service number on the back of *your* identification (ID) card prior to *services* being rendered or to request a directory.

COVERED AND NON-COVERED EXPENSES

Benefits are payable only if *services* are considered to be a *covered expense* and are subject to the specific conditions, limitations and applicable maximums of this *Plan*. The benefit payable for *covered expenses* will <u>not</u> exceed the *maximum allowable fee(s)*.

A *covered expense* is deemed to be incurred on the date a covered *service* is received. The bill submitted by the *provider*, if any, will determine which benefit provision is applicable for payment of *covered expenses*.

If *you* incur non-*covered expenses*, whether from a *PAR provider* or a *Non-PAR provider*, *you* are responsible for making the full payment to the *provider*. The fact that a *provider* has performed or prescribed a medically appropriate procedure, treatment, or supply, or the fact that it may be the only available treatment for a *bodily injury* or *sickness* does not mean that the procedure, treatment or supply is covered under this *Plan*.

Please refer to the "Schedule of Benefits", “Medical Covered Expenses” and the "Limitations and Exclusions" sections of this *Summary Plan Description* for more information about *covered expenses* and non-*covered expenses*.

SCHEDULE OF BENEFITS

IMPORTANT INFORMATION ABOUT PLAN BENEFITS

Benefits and limits (e.g. visit or dollar limits) are per *calendar year*, unless specifically stated otherwise.

When benefit limits apply (e.g. visit or dollar limits), *PAR* and *Non-PAR provider* benefits accumulate together, unless specifically stated otherwise.

This schedule provides an overview of the *Plan* benefits. For a more detailed description of *Plan* benefits, refer to the "Medical Covered Expenses" section.

DEDUCTIBLES, COINSURANCE, OUT-OF-POCKET LIMITS AND LIFETIME MAXIMUM BENEFIT		
BENEFIT FEATURES	**PAR PROVIDER BENEFIT (IN-NETWORK)**	**NON-PAR PROVIDER BENEFIT (OUT-OF-NETWORK)**
Individual *Deductible*	$500 per *covered person*	$1,500 per *covered person*
Family *Deductible*	$1,500 (embedded) per covered family	$3,000 (embedded) per covered family
If *you* have more than one family member covered under *your* plan, one family member may satisfy the individual $500 *deductible* and the remaining $1,000 family *deductible* may be met by any combination of the remaining family member's *claims* up to the $1,500 family *deductible* maximum. Here are the *deductible* rules: • No single family member will pay more than $500 in *deductible*; • No single family member can contribute more than $500 to the family *deductible* maximum; and • Of the $1,500 family maximum *deductible*, $500 can be met by a family member and the remaining $1,000 can be met by a combination of additional family members; or • All family members' *services* can be combined and applied to meet the family $1,500 *deductible*.		
Coinsurance	The *Plan* pays 75%, *you* pay 25%.	The *Plan* pays 50%, *you* pay 50%.
Individual *Out-of-Pocket Limit* (Includes *Deductible*)	$3,500 per *covered person*	$5,000per *covered person*

DEDUCTIBLES, COINSURANCE, OUT-OF-POCKET LIMITS AND LIFETIME MAXIMUM BENEFIT

BENEFIT FEATURES	PAR PROVIDER BENEFIT (IN-NETWORK)	NON-PAR PROVIDER BENEFIT (OUT-OF-NETWORK)
Family *Out-of-Pocket Limit* (Includes *Deductible*)	$7,000 per covered family	$9,500 per covered family

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

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

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

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

Lifetime Maximum Benefit	Unlimited	Unlimited

Primary Care Physician (PCP) is defined as a family practice physician, pediatrician, doctor of internal medicine, general practitioner, OBGYN, chiropractor, nurse practitioner, *physician assistant*, registered nurse, optometrist and retail / minute clinic. A specialist (including specialty nurse practitioner, specialty RN's and specialty PA's) would be all other *qualified practitioners*.

ROUTINE/PREVENTIVE CHILD CARE SERVICES BIRTH TO AGE 18 (*Services* Received at a Clinic or Outpatient *Hospital*)		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT (IN-NETWORK)**	**NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)**
Routine Child Care Examination (including routine vision and hearing screening when part of a *qualified practitioner primary care physician* examination)	Payable at 100%	Payable at 100%
Childhood Obesity Examination (children between the ages of 3 and 18 only)	Payable at 100%	Payable at 100%
Childhood Obesity Nutritional Counseling with a Nutritionist or Dietician who is a Registered Dietician (children between the ages of 3 and 18 only)	Payable at 100%	Payable at 100%
Childhood Obesity Examination/Nutritional Counseling Limits	8 visits per eligible covered *dependent* child per *calendar year*	
Routine Child Care Laboratory and X-ray	Payable at 100%	Payable at 100%
Routine Child Care Immunizations	Payable at 100%	Payable at 100%

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

ROUTINE/PREVENTIVE CHILD CARE SERVICES BIRTH TO AGE 18 (*Services* Received at a Clinic or Outpatient *Hospital*)		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT (IN-NETWORK)**	**NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)**
Routine Child Care HPV Vaccine (e.g. Gardasil) covered males and females persons beginning at age 9	Payable the same as routine child care immunizations.	Payable the same as routine child care immunizations.
Routine Child Care Meningitis Vaccine	Payable the same as routine child care immunizations.	Payable the same as routine child care immunizations.
Routine Child Care Flu/Pneumonia Injections	Payable at 100%	Payable at 100%

ROUTINE/PREVENTIVE ADULT CARE SERVICES AGE 18 AND OVER (*Services* Received at a Clinic or Outpatient *Hospital*)		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT (IN-NETWORK)**	**NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)**
Routine Adult Care Examination (including routine vision and hearing screening when part of a *qualified practitioner primary care physician* examination)	Payable at 100%	Payable at 100%

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

ROUTINE/PREVENTIVE ADULT CARE SERVICES AGE 18 AND OVER (*Services* Received at a Clinic or Outpatient *Hospital*)		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT (IN-NETWORK)**	**NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)**
Routine Adult Care Laboratory and X-ray	Payable at 100%	Payable at 100%
Routine Adult Care Immunizations	Payable at 100%	Payable at 100%
HPV Vaccine (e.g. Gardasil) for covered male and female persons through age 26	Payable at 100%	Payable at 100%
Shingles Vaccine (e.g. Zostavax) for *covered persons* age 50 and over	Payable at 100%	Payable at 100%
Routine Adult Care Meningitis Vaccine *covered persons* through age 25	Payable at 100%	Payable at 100%
Routine Adult Care Flu/Pneumonia Injections	Payable at 100%	Payable at 100%
Routine Adult Care H1N1 Vaccine	Payable at 100%	Payable at 100%
Routine Adult Care Mammograms	Payable at 100%	Payable at 100%

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

ROUTINE/PREVENTIVE ADULT CARE SERVICES AGE 18 AND OVER (*Services* Received at a Clinic or Outpatient *Hospital*)		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT (IN-NETWORK)**	**NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)**
Routine Adult Care Pap Smears	Payable at 100%	Payable at 100%
Routine Adult Care Colonoscopy, Proctosigmoidoscopy and Sigmoidoscopy Screenings (including related *services*) (performed at an *outpatient* facility, *ambulatory surgical center* or clinic location). Removal of polyps during a routine colonoscopy will be payable as a preventive procedure.	Payable at 100%	Payable at 100%
Prostate Specific Antigen (PSA) Testing	Payable at 100%	Payable at 100%
Physical Examination Yearly Visit Limits	1 visit per *covered person*	
Well Woman Examination Yearly Visit Limits	1 visit per *covered person*	
Sometimes during the course of a screening procedure (routine wellness or preventive care), abnormalities or problems may be identified that require immediate intervention or additional diagnosis. If this occurs, and *your provider* performs additional necessary procedures, the *service* will be considered diagnostic and/or surgical, rather than screening, depending on the *claim* for the *services* submitted by *your provider*. This may result in a possible difference in *your copayment* and/or *coinsurance*.		

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

ROUTINE VISION SERVICES		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT (IN-NETWORK)**	**NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)**
Routine Vision Examination	Not Covered	Not Covered
Routine Vision Refraction	Not Covered	Not Covered
Eyeglass Frames and Lenses and Contact Lenses	Not Covered	Not Covered

HEARING AIDS AND RELATED SERVICES BIRTH THROUGH AGE 17		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT (IN-NETWORK)**	**NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)**
Routine Hearing Examination and Testing	Not Covered	Not Covered
Hearing Aids and Fitting	75% after *deductible*	50% after *deductible*
Hearing Aids and Fitting Limits	$1,400 per *covered person* through age 17, per hearing impaired ear, once every 36 months.	

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

QUALIFIED PRACTITIONER SERVICES (Other than *Qualified Practitioner Services* covered under the Routine / Preventive Care Benefits)		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT (IN-NETWORK)**	**NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)**
Diagnostic Office Examination at a Clinic, including Second Surgical Opinion – *Qualified Practitioner Primary Care Physician*	75% after *deductible*	50% after *deductible*
Diagnostic Office Examination at a Clinic, including Second Surgical Opinion - *Qualified Practitioner* Specialist	75% after *deductible*	50% after *deductible*
If an office examination is billed from an *outpatient* location, the *services* will be payable the same as an office examination at a clinic.		
Diagnostic Laboratory and X-ray at a Clinic (other than *advanced imaging*)	75% after *deductible*	50% after *deductible*
Independent Laboratory	Payable the same as diagnostic laboratory and x-ray.	Payable the same as diagnostic laboratory and x-ray.
Advanced Imaging at a Clinic	75% after *deductible*	50% after *deductible*
Allergy Testing at a Clinic	75% after *deductible*	50% after *deductible*

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

QUALIFIED PRACTITIONER SERVICES (Other than Qualified Practitioner Services covered under the Routine / Preventive Care Benefits)		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT (IN-NETWORK)**	**NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)**
Allergy Serum/Vials at a Clinic	75% after *deductible*	50% after *deductible*
Allergy Injections at a Clinic	75% after *deductible*	50% after *deductible*
Injections at a Clinic (other than routine immunizations, HPV vaccine, meningitis vaccine, shingles vaccine, flu/pneumonia injections, contraceptive injections for birth control reasons and allergy injections)	75% after *deductible*	50% after *deductible*
Anesthesia at a Clinic	75% after *deductible*	50% after *deductible*
Surgery at a Clinic (including *Qualified Practitioner*, Assistant Surgeon and *Physician Assistant*)	75% after *deductible*	50% after *deductible*
Medical and Surgical Supplies	75% after *deductible*	50% after *deductible*
Eyeglasses or Contact Lenses after Cataract *Surgery* (initial pair only)	75% after *deductible*	50% after *deductible*

QUALIFIED PRACTITIONER SERVICES (Other than Qualified Practitioner Services covered under the Routine / Preventive Care Benefits)		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT (IN-NETWORK)**	**NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)**
Diabetic Counseling and Diabetic Nutritional Counseling (*Diabetes Self-Management Training*) (all places of *service*)	75% after *deductible*	50% after *deductible*
Diabetes Supplies	Payable under the *prescription* drug benefits.	Payable under the *prescription* drug benefits.

DENTAL/ORAL SURGERIES COVERED UNDER THE MEDICAL PLAN		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT (IN-NETWORK)**	**NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)**
Dental/Oral *Surgeries*	Payable the same as any other *sickness*.	Payable the same as any other *sickness*.
Please refer to the Medical Covered Expenses section, Dental/Oral Surgeries Covered Under the Medical Plan, for a list of oral surgeries covered under this benefit.		

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

FAMILY PLANNING		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT (IN-NETWORK)**	**NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)**
Birth Control Pills and Patches	Not Covered under Medical, refer to *your* Pharmacy Benefit	Not Covered under Medical, refer to *your* Pharmacy Benefit
Contraceptive Devices (e.g. IUD; Diaphragms) Over-the-counter contraceptive devices are not covered.	75% after *deductible*	50% after *deductible*
Contraceptive Injections	75% after *deductible*	50% after *deductible*
Contraceptive Implant Systems (e.g. Norplant) – Insertion and Removal	75% after *deductible*	50% after *deductible*
Sterilization	Payable the same as any other *sickness*.	Payable the same as any other *sickness*.
Life Threatening Abortions	Payable the same as any other *sickness*.	Payable the same as any other *sickness*.

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

MATERNITY (Normal, C-Section and Complications)		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT (IN-NETWORK)**	**NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)**
Inpatient Hospital Room and Board and Ancillary Facility *Services*	Payable the same as any other *sickness*.	Payable the same as any other *sickness*.
Birthing Center Room and Board and Ancillary *Services*	Payable the same as any other *sickness*.	Payable the same as any other *sickness*.
Qualified Practitioner Services	Payable the same as any other *sickness*.	Payable the same as any other *sickness*.
Dependent Daughter Maternity	Payable the same as any other *sickness*.	Payable the same as any other *sickness*.
Newborn *Inpatient Qualified Practitioner Services*	75% after *deductible*	50% after *deductible*
Newborn *Inpatient* Facility *Services*	75% The newborn *deductible* will be waived for facility *services*.	50% The newborn *deductible* will be waived for facility *services*.

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

INPATIENT SERVICES		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT (IN-NETWORK)**	**NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)**
Inpatient Hospital Room and Board and Ancillary Facility *Services*	75% after *deductible*	50% after *deductible*
Qualified Practitioner Inpatient Hospital Visit	75% after *deductible*	50% after *deductible*
Qualified Practitioner Inpatient Surgery and Anesthesia	75% after *deductible*	50% after *deductible*
Qualified Practitioner Inpatient Pathology and Radiology	75% after *deductible*	50% after *deductible*
Private Duty Nursing	Not Covered	Not Covered

SKILLED NURSING SERVICES		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT (IN-NETWORK)**	**NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)**
Skilled Nursing Room and Board and Ancillary Facility *Services*	75% after *deductible*	50% after *deductible*
Skilled Nursing Facility Yearly Limits	30 day(s) per *covered person*	

SKILLED NURSING SERVICES		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT (IN-NETWORK)**	**NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)**
Skilled Nursing *Qualified Practitioner* Visit	75% after *deductible*	50% after *deductible*

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

OUTPATIENT AND AMBULATORY SURGICAL CENTER SERVICES		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT (IN-NETWORK)**	**NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)**
Ambulatory Surgical Center Facility *Services*	75% after *deductible*	50% after *deductible*
Ambulatory Surgical Center Ancillary *Services*	75% after *deductible*	50% after *deductible*
Outpatient Hospital Facility Surgical *Services*	75% after *deductible*	50% after *deductible*
Outpatient Hospital Facility Non-Surgical *Services* (e.g. clinic facility *services*; observation)	75% after *deductible*	50% after *deductible*
Outpatient Hospital Surgical and Non-Surgical Ancillary *Services* (e.g. supplies; medication; anesthesia)	75% after *deductible*	50% after *deductible*

OUTPATIENT AND AMBULATORY SURGICAL CENTER SERVICES		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT (IN-NETWORK)**	**NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)**
Outpatient Hospital Facility Diagnostic Laboratory and X-ray (other than *advanced imaging*)	75% after *deductible*	50% after *deductible*
Preadmission Testing	75% after *deductible*	50% after *deductible*
Outpatient Hospital Facility *Advanced Imaging*	75% after *deductible*	50% after *deductible*
Outpatient Hospital and *Ambulatory Surgical Center Qualified Practitioner* Visit	75% after *deductible*	50% after *deductible*
Outpatient Hospital and *Ambulatory Surgical Center Surgery* (including surgeon; assistant surgeon; and *physician assistant*) and Anesthesia	75% after *deductible*	50% after *deductible*
Outpatient Hospital and *Ambulatory Surgical Center* Pathology and Radiology	75% after *deductible*	50% after *deductible*

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

EMERGENCY AND URGENT CARE SERVICES		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT (IN-NETWORK)**	**NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)**
Emergency Room Facility *Services* (true *emergency*) If a *copayment* applies and *you* are admitted to the *hospital*, the *copayment* will be waived.	75% after *deductible* and after a $50 *copayment*	50% after *deductible* and after a $50 *copayment*
Emergency Room Ancillary *Services* (i.e. laboratory; x-ray; supplies) (true *emergency*)	75% after *deductible*	50% after *deductible*
Emergency Room All Physician *Services* (including Radiologist, Pathologist, Anesthesiologist and ancillary *services* billed by an Emergency Room Physician) (true *emergency*)	75% after *deductible*	50% after *deductible*
Emergency Room Facility *Services* (non-emergency) If a *copayment* applies and *you* are admitted to the *hospital*, the *copayment* will be waived.	75% after *deductible* and after a $50 *copayment*	50% after *deductible* and after a $50 *copayment*
Emergency Room Ancillary *Services* (e.g. laboratory; x-ray; supplies) (non-emergency)	75% after *deductible*	50% after *deductible*

EMERGENCY AND URGENT CARE SERVICES		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT (IN-NETWORK)**	**NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)**
Emergency Room All Physician *Services* (including Radiologist, Pathologist, Anesthesiologist and ancillary *services* billed by an Emergency Room Physician) (non-emergency)	75% after *deductible*	50% after *deductible*
Urgent Care Center (facility, ancillary *services* and *qualified practitioner services*)	75% after *deductible*	50% after *deductible*

HOSPICE SERVICES		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT (IN-NETWORK)**	**NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)**
Hospice Inpatient Room and Board and Ancillary *Services*	100%	100%
Hospice Outpatient (including *hospice* home visits)	100%	100%
Hospice Qualified Practitioner Visit	100%	100%

HOME HEALTH CARE SERVICES		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT (IN-NETWORK)**	**NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)**
Home Health Care *Services*	75% after *deductible*	50% after *deductible*
Home Health Care Yearly Limits	60 visit(s) per *covered person*	
Home therapy benefits will be reimbursed under the home health care benefit. If therapies are done in the home (such as physical or occupational therapy), these therapy *services* will apply to the home health care limits. If therapies and home health visits are done on the same day the *services* will track as one visit per day.		
Home Health Care Ancillary *Services* (excluding *durable medical equipment*, prosthetics and private duty nursing)	75% after *deductible*	50% after *deductible*

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

DURABLE MEDICAL EQUIPMENT (DME)		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT (IN-NETWORK)**	**NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)**
Durable Medical Equipment (DME)	75% after *deductible*	50% after *deductible*
Prosthesis	75% after *deductible*	50% after *deductible*

DURABLE MEDICAL EQUIPMENT (DME)		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT (IN-NETWORK)**	**NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)**
Wigs	Not Covered	Not Covered

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

AMBULANCE SERVICES		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT (IN-NETWORK)**	**NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)**
Ground *Ambulance*	75% after *deductible*	Payable the same as *PAR Provider* Benefit per billed charges
Air *Ambulance*	75% after *deductible*	Payable the same as *PAR Provider* Benefit per billed charges

MORBID OBESITY SERVICES		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT (IN-NETWORK)**	**NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)**
The following *service* will be covered under the *morbid obesity* benefit: *bariatric surgery*.		
Morbid Obesity	Payable the same as any other *sickness*.	Payable the same as any other *sickness*.

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

TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ)		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT (IN-NETWORK)**	**NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)**
Temporomandibular Joint Dysfunction (TMJ) (Other than Splint/Appliances)	Payable the same as any other *sickness*.	Payable the same as any other *sickness*.
Temporomandibular Joint Dysfunction (TMJ) Splint/Appliances	Payable the same as any other *sickness*.	Payable the same as any other *sickness*.

DENTAL INJURY SERVICES		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT (IN-NETWORK)**	**NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)**
Dental Injuries	Payable the same as any other *sickness*.	Payable the same as any other *sickness*.
Please see the Medical Covered Expenses section, Dental Injury, for benefit details.		

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

INFERTILITY SERVICES		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT (IN-NETWORK)**	**NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)**
Infertility Counseling and Treatment	Not Covered	Not Covered
Artificial Means of Achieving Pregnancy	Not Covered	Not Covered
Sexual Dysfunction/Impotence	Not Covered	Not Covered
Sexual Dysfunction/Impotence related to a *Mental Health* Disorder	Not Covered	Not Covered

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

THERAPY SERVICES		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT (IN-NETWORK)**	**NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)**
Chiropractic Examinations	75% after *deductible*	50% after *deductible*
Chiropractic Laboratory and X-ray	75% after *deductible*	50% after *deductible*
Chiropractic Manipulations	75% after *deductible*	50% after *deductible*
Chiropractic Therapy	75% after *deductible*	50% after *deductible*
Chiropractic Limits	26 visit(s) per *covered person*, with no more than 1 visit per day The visit limit applies to the following chiropractic benefits: therapies; and manipulations.	
Physical therapy when provided by a chiropractor will deplete the chiropractic limits.		
Physical Therapy (Clinic and *Outpatient*)	75% after *deductible*	50% after *deductible*
Physical Therapy Limits	Up to 30 visit(s) per *calendar year*. May require an authorization.	
Occupational Therapy (Clinic and *Outpatient*)	75% after *deductible*	50% after *deductible*
Occupational Therapy Limits	Up to 30 visit(s) per *calendar year*. May require an authorization.	
Speech Therapy (Clinic and *Outpatient*)	75% after *deductible*	50% after *deductible*

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

THERAPY SERVICES		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT (IN-NETWORK)**	**NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)**
Speech Therapy Limits	Up to 30 visit(s) per *calendar year*. May require an authorization.	
Cognitive Therapy (Clinic and *Outpatient*)	75% after *deductible*	50% after *deductible*
Cognitive Therapy Limits	30 visit(s) per *covered person*	
Therapy Education (Clinic and *Outpatient*)	75% after *deductible*	50% after *deductible*
Physical, occupational, speech and cognitive therapies and chiropractic *services* have separate limits.		
Acupuncture	Not Covered	Not Covered
Respiratory Therapy and Pulmonary Therapy (Clinic and *Outpatient*)	75% after *deductible*	50% after *deductible*
Vision Therapy (eye exercises to strengthen the muscles of the eye) (Clinic and *Outpatient*)	Not Covered	Not Covered
Chemotherapy (Clinic and *Outpatient*)	75% after *deductible*	50% after *deductible*
Radiation Therapy (Clinic and *Outpatient*)	75% after *deductible*	50% after *deductible*

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

THERAPY SERVICES		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT (IN-NETWORK)**	**NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)**
Cardiac Rehabilitation (Phase II) Phase I is covered under the *inpatient* facility benefits. Phase III, an unsupervised exercise program, is not covered.	75% after *deductible*	50% after *deductible*
Cardiac Rehabilitation Limits	30 visit(s) per *covered person*	

TRANSPLANT SERVICES		
MEDICAL SERVICES	**HUMANA NATIONAL TRANSPLANT NETWORK (NTN) FACILITY (Payable at the *PAR Provider* Benefit Level) (IN-NETWORK)**	**NON-HUMANA NATIONAL TRANSPLANT NETWORK (NTN) FACILITY (Payable at the *Non-PAR Provider* Benefit Level)* (OUT-OF-NETWORK)**
Organ Transplant Medical *Services*	Payable the same as any other *sickness*.	Payable the same as any other *sickness*.
Non-Medical *Services* - Lodging (Limitations apply. See pages 60-62)	75% after *deductible*	50% after *deductible*

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

TRANSPLANT SERVICES		
MEDICAL SERVICES	**HUMANA NATIONAL TRANSPLANT NETWORK (NTN) FACILITY (Payable at the *PAR Provider* Benefit Level) (IN-NETWORK)**	**NON-HUMANA NATIONAL TRANSPLANT NETWORK (NTN) FACILITY (Payable at the *Non-PAR Provider* Benefit Level)* (OUT-OF-NETWORK)**
Non-Medical *Services* - Transportation (Limitations apply. See pages 60-62)	75% after *deductible*	50% after *deductible*
Organ Transplant Medical *Services* Limits	Lifetime maximum of the *Plan*.	
Non-Medical *Services* - Lodging Limits	$10,000 per covered transplant	
Non-Medical *Services* - Transportation Limits	$10,000 per covered transplant	
Lodging and transportation limits are combined.		
Covered expenses for organ transplants performed at a Humana National Transplant Network facility and at a facility other than a Humana National Transplant Network facility will aggregate toward the *Plan out-of-pocket limits*.		

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

BEHAVIORAL HEALTH INPATIENT SERVICES		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT (IN-NETWORK)**	**NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)**
Inpatient Behavioral Health Room and Board and Ancillary *Services*	Payable the same as Medical *Inpatient Hospital*.	Payable the same as Medical *Inpatient Hospital*.
Inpatient Behavioral Health Professional *Services*	Payable the same as Medical *Inpatient* Physician.	Payable the same as Medical *Inpatient* Physician.
Behavioral Health Partial Hospitalization	Payable the same as Medical *Outpatient Hospital*.	Payable the same as Medical *Outpatient Hospital*.
Behavioral Health Residential Treatment Facility Services	Not Covered	Not Covered
Behavioral Health Half-way House *Services*	Not Covered	Not Covered
The *inpatient behavioral health coinsurance* amounts will reduce the *Plan out-of-pocket limits*.		

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

BEHAVIORAL HEALTH CLINIC, OUTPATIENT AND INTENSIVE OUTPATIENT SERVICES		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT (IN-NETWORK)**	**NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)**
Behavioral Health Therapy *Services* (Clinic, *Outpatient* and *Intensive Outpatient*)	Payable the same as Medical Specialist Office Visit.	Payable the same as Medical Specialist Office Visit.
Diagnostic Examination (Clinic)	Payable the same as any other *sickness*.	Payable the same as any other *sickness*.
Laboratory and X-ray (Clinic and *Outpatient*)	Payable the same as any other *sickness*.	Payable the same as any other *sickness*.
The clinic, *outpatient* and *intensive outpatient behavioral health coinsurance* amounts will reduce the *Plan out-of-pocket limits*.		

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

AUTISM SERVICES		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT (IN-NETWORK)**	**NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)**
Rehabilitative and Therapeutic Care	75% after *deductible*	50% after *deductible*
Respite Care for *covered person* age 1-21	75% after *deductible*, and does not apply to the out-of-pocket maximum	Payable the same as *PAR Provider* Benefit, and does not apply to the out-of-pocket maximum

AUTISM SERVICES		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT (IN-NETWORK)**	**NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)**
Autism Respite *Services* Limit	$375 monthly benefit (s) per *covered person*	
Autism Services Limit Age 1 – 6 Age 7 – 21	 $50,000 per *covered person* per *calendar year* $1,000 monthly benefit (s) per *covered person*	
Therapy *services* for *autism* are first payable under the specific therapy benefit and once those limits are exhausted, *services* are covered under the *autism* benefit.		

OTHER COVERED EXPENSES		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT (IN-NETWORK)**	**NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)**
Other Covered Expenses	Payable the same as any other *sickness*.	Payable the same as any other *sickness*.

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

HOW BENEFITS PAY

This *Plan* requires *you* to satisfy a *deductible(s)* before this *Plan* begins to share the cost of most medical *services*. A *deductible* is required to be met before benefits are payable under this *Plan*, when it is satisfied, this *Plan* will share the cost of *covered expenses* at the *coinsurance* percentage until *you* have reached any applicable *out-of-pocket limit*. After *you* have met the *out-of-pocket limit*, if any, this *Plan* will pay *covered expenses* at 100% for the rest of the *calendar year*, subject to the *maximum allowable fee(s)*, any *maximum benefits* and all other terms, provisions, limitations and exclusions of this *Plan*. Any applicable *deductible*, *coinsurance* and *out-of-pocket* amounts, medical *services* and medical *service* limits are stated on the Schedule of Benefits.

DEDUCTIBLE

A *deductible* is a specified dollar amount that must be satisfied, either individually or combined as a covered family, per *calendar year* before this *Plan* pays benefits for certain specified *services*. Only charges which qualify as a *covered expense* may be used to satisfy the *deductible*. *Copayments* do not apply toward the *deductible*. *Copayments* will continue to be the responsibility of the *covered person.* The individual and family *deductible* amounts are stated on the Schedule of Benefits.

The individual *deductible* applies to each *covered person* each *calendar year* up to the family maximum. Once a *covered person* meets their individual *deductible*, this *Plan* will begin to pay benefits for that *covered person.*

The total *deductible* applied to all *covered persons* in one family in a *calendar year*. No one individual is required to meet the total family *deductible*. Once *you* and/or *your* covered *dependents* meet the family *deductible*, any remaining *deductible* for a *covered person* in the family will be waived for that year. This *Plan* will begin to pay benefits for all *covered persons* in the family.

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

- No single family member will pay more than $500 in *deductible*;
- No single family member can contribute more than $500 to the family *deductible* maximum; and
- Of the $1,500 family maximum *deductible*, $500 can be met by a family member and the remaining $1,000 can be met by a combination of additional family members; or
- All family members' *services* can be combined and applied to meet the family $1,500 *deductible*.

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

COINSURANCE

Coinsurance means the shared financial responsibility for *covered expenses* between the *covered person* and this *Plan*.

Covered expenses are payable at the applicable *coinsurance* percentage rate shown on the Schedule of Benefits after the *deductible*, if any, is satisfied each *calendar year*, subject to any *calendar year* maximums of this *Plan*.

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

OUT-OF-POCKET LIMIT

An *out-of-pocket limit* is a specified dollar amount that must be satisfied, either individually or combined as a covered family, per *calendar year* before a benefit percentage will be increased. The individual and family *out-of-pocket limits* are stated on the Schedule of Benefits.

Once a *covered person* satisfies the individual *out-of-pocket limits*, which includes the *deductible*, this *Plan* will pay 100% of *covered expenses* for the remainder of the *calendar year* for that *covered person*, unless specifically indicated, subject to any *calendar year* maximums of this *Plan*.

Once *you* and/or *your* covered *dependents* satisfy the family *out-of-pocket limits*, which includes the *deductible*, this *Plan* will pay 100% of *covered expenses* for the remainder of the *calendar year* for the family, unless specifically indicated, subject to any *calendar year* maximums of this *Plan*. *Copayments* will continue to be the responsibility of the *covered person.*

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

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

Penalties, *copayments* and charges above the allowable fee for *Non-PAR providers* do not apply to the *out-of-pocket limits*. *Copayments* will continue to be the responsibility of the *covered person.*

LIFETIME MAXIMUM BENEFIT

This *Plan* does not include a lifetime maximum.

ROUTINE/PREVENTIVE CHILD CARE SERVICES

Routine/preventive child care *services* are payable as shown on the Schedule of Benefits, if *your* covered *dependent* is not *confined* in a *hospital* or *qualified treatment facility*, and if such expenses are not incurred for diagnosis of a specific *bodily injury* or *sickness*.

The exclusion for *services* which are not *medically necessary* does not apply to routine/preventive care *services*, except for *childhood obesity*.

No benefits are payable under this routine/preventive care benefit for a medical examination for a *bodily injury* or *sickness*, a medical examination caused by or resulting from pregnancy, or a dental examination.

Childhood Obesity

Childhood obesity examinations are provided for discussion of weight loss issues and obesity counseling with *your* eligible covered *dependent* child's *qualified practitioner*. *Childhood obesity* nutritional counseling is provided to help *your* eligible covered *dependent* child develop a weight management program with a nutritionist or dietician who is a Registered Dietician.

ROUTINE/PREVENTIVE ADULT CARE SERVICES

Routine/preventive adult care *services* are payable as shown on the Schedule of Benefits, if *you* or *your* covered *dependent* are not *confined* in a *hospital* or *qualified treatment facility*, and if such expenses are not incurred for diagnosis of a specific *bodily injury* or *sickness*.

The exclusion for *services* which are not *medically necessary* does not apply to routine/preventive care *services*.

No benefits are payable under this routine/preventive care benefit for a medical examination for a *bodily injury* or *sickness*, a medical examination caused by or resulting from pregnancy, or a dental examination.

HEARING AIDS AND RELATED SERVICES

Hearing aids and related *services* are payable as shown on the Schedule of Benefits. The full cost of one (1) *hearing aid* per hearing impaired ear up to $1,400 every 36 months for *hearing aids* for a *covered person* through the age of 17 and all related *services* which shall be prescribed by an audiologist and dispensed by an audiologist or hearing instrument specialist. The *covered person* may choose a higher priced *hearing aid* and may pay the difference in cost above the $1,400 limit as provided.

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

QUALIFIED PRACTITIONER SERVICES

Qualified practitioner services are payable as shown on the Schedule of Benefits.

Second Surgical Opinion

If *you* obtain a second surgical opinion, the *qualified practitioners* providing the surgical opinions MUST NOT be in the same group practice or clinic. If the two opinions disagree, *you* may obtain a third opinion. Benefits for the third opinion are payable the same as for the second opinion. The *qualified practitioner* providing the second or third surgical opinion may confirm the need for *surgery* or present other treatment options. The decision whether or not to have the *surgery* is always *yours*.

Multiple Surgical Procedures

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

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

No benefits will be payable for incidental procedures.

Assistant Surgeon

Assistant surgeon benefits are payable at 20% of the *maximum allowable fee* allowed for the primary surgeon.

Physician Assistant

Physician assistant benefits are payable at 20% of the *maximum allowable fee* allowed for the primary surgeon.

DENTAL/ORAL SURGERIES COVERED UNDER THE MEDICAL PLAN

Oral surgical operations due to a *bodily injury* or *sickness* are payable as shown on the Schedule of Benefits and include the following procedures:

1. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological examination;

2. Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;

3. Reduction of fractures and dislocations of the jaw; and

4. Incision of accessory sinuses, salivary glands or ducts.

FAMILY PLANNING

Family planning *services* are payable as shown on the Schedule of Benefits.

The exclusion for *services* which are not *medically necessary* does not apply to family planning *services*, except life-threatening abortions.

MATERNITY

Maternity *services*, including normal maternity, c-section and complications, are payable as shown on the Schedule of Benefits.

Maternity benefits are subject to all terms and provisions of this *Plan*, with the exception of the *pre-existing condition* limitation as defined within the Definitions section.

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending *provider*, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). An attending *provider* is defined as an individual who is licensed under applicable state law to provide maternal or pediatric care and who is directly responsible for providing such care to a mother or newborn child. The definition of attending *provider* does not include a plan, *hospital*, managed care organization or other issuer. In any case, plans may not, under Federal law, require that a *provider* obtain authorization from the *Plan* or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

MATERNITY PROGRAM

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

The maternity program offers *you*:

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

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

Newborns

Covered expenses incurred during a newborn child's initial *inpatient hospital confinement* include *hospital* expenses for nursery room and board and miscellaneous *services*, *qualified practitioner's* expenses for circumcision and *qualified practitioner's* expenses for routine examination before release from the *hospital*. *Covered expenses* also include *services* for the treatment of a *bodily injury* or *sickness*, care or treatment for premature birth and medically diagnosed birth defects and abnormalities. The *deductible* is waived for the first 31 days of life.

Newborn benefits are subject to all terms and provisions of this *Plan*, with the exception of the *pre-existing condition* limitation as defined within the Definitions section. Please refer to the Eligibility and Effective Date of Coverage section regarding newborn eligibility and enrollment.

Birthing Centers

A birthing center is a free standing facility, licensed by the state, which provides prenatal care, delivery, immediate postpartum care and care of the newborn child. *Services* are payable when incurred within 48 hours after *confinement* in a birthing center for *services* and supplies furnished for prenatal care and delivery.

INPATIENT HOSPITAL

Inpatient hospital services are payable as shown on the Schedule of Benefits, and include charges made by a *hospital* for daily semi-private, ward, intensive care or coronary care room and board charges for each day of *confinement* and *services* furnished for *your* treatment during *confinement*.

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

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

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

SKILLED NURSING FACILITY

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

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

1. Begins while *you* or an eligible *dependent* are covered under this *Plan*;

2. Begins after discharge from a *hospital confinement* or a prior covered skilled nursing facility *confinement*;

3. Is necessary for care or treatment of the same *bodily injury* or *sickness* which caused the prior *confinement*; and

4. Occurs while *you* or an eligible *dependent* are under the regular care of a physician.

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

1. Permanent and full-time bed care facilities for resident patients;

2. A physician's *services* available at all times;

3. 24-hour-a-day skilled nursing *services* under the full-time supervision of a physician or registered nurse (R.N.);

4. A daily record for each patient;

5. Continuous *skilled nursing care* for sick or injured persons during their convalescence from *sickness* or *bodily injury*; and

6. A utilization review plan.

A skilled nursing facility is not except by incident, a rest home, a home for care of the aged, or engaged in the care and treatment of *mental health* or *substance abuse*.

OUTPATIENT AND AMBULATORY SURGICAL CENTER

Outpatient facility and *ambulatory surgical center services* are payable as shown on the Schedule of Benefits.

Outpatient surgery includes but is not limited to facility *services* and supplies, anesthesia, anesthesia supplies, and *services* rendered by an employee of the facility other than the surgeon or assistant surgeon.

Ancillary *services* listed below and furnished to a *covered person* in an *outpatient* facility, if pre-authorized by the *Plan*:

1. Use of operating room and recovery rooms;

2. Respiratory therapy e.g., oxygen;

3. Administered drugs and medicine;

4. Intravenous solutions;

5. Dressings, including ordinary casts, splints, or trusses;

6. Anesthetics and their administration;

7. Transfusion supplies and equipment;

8. *Diagnostic services*, including radiology, ultrasound, laboratory, pathology, and approved machine testing e.g., electrocardiogram (EKG);

9. Chemotherapy treatment for proven malignant disease;

10. Radiation therapy; treatment by x-ray, radium or radioactive isotopes; and

11. Renal dialysis treatment for acute or chronic kidney ailment which may include the supportive use of an artificial kidney machine.

EMERGENCY AND URGENT CARE SERVICES

Emergency and *urgent care services* are payable as shown on the Schedule of Benefits.

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

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

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

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

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

1. Is required to prevent serious deterioration in the *covered person's* health;

2. Could not have been foreseen prior to leaving the *service area* or during normal office hours;

3. Is not an *emergency* medical condition, but requires prompt medical attention;

4. Includes, but is not limited to, the treatment of significant injuries as a result of accidents, the relief or elimination of severe pain, or the moderation of an acute illness; and

5. Is obtained in accordance with the benefit booklet *plan delivery system rules*.

HOSPICE SERVICES

Hospice services are payable as shown on the Schedule of Benefits, and must be furnished in a *hospice* facility or in *your* home. A *qualified practitioner* must certify *you* are terminally ill with a life expectancy of six months or less.

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

Covered expenses are payable for the following *hospice services*:

1. Room and board and other *services* and supplies;

2. Part-time nursing care by, or supervised by, a registered nurse for up to 8 hours per day;

3. Counseling *services* by a *qualified practitioner* for the *hospice* patient and the immediate family;

4. Medical social *services* provided to *you* or *your* immediate family under the direction of a *qualified practitioner*, which include the following:
   a. Assessment of social, emotional and medical needs, and the home and family situation;
   b. Identification of the community resources available; and
   c. Assistance in obtaining those resources;

5. Nutritional counseling;

6. Physical or occupational therapy;

7. Part-time home health aide service for up to 8 hours in any one day;

8. Medical supplies, drugs and medicines prescribed by a *qualified practitioner*.

Hospice care benefits do NOT include:

1. Private duty nursing *services* when *confined* in a *hospice* facility;

2. A *confinement* not required for pain control or other acute chronic symptom management;

3. Funeral arrangements;

4. Financial or legal counseling, including estate planning or drafting of a will;

5. Homemaker or caretaker *services*, including a sitter or companion *services*;

6. Housecleaning and household maintenance;

7. *Services* of a social worker other than a licensed clinical social worker;

8. *Services* by volunteers or persons who do not regularly charge for their *services*; or

9. *Services* by a licensed pastoral counselor to a member of his or her congregation when *services* are in the course of the duties to which he or she is called as a pastor or minister.

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

Hospice facility means a licensed facility or part of a facility which principally provides *hospice* care, keeps medical records of each patient, has an ongoing quality assurance program and has a physician on call at all times. A *hospice* facility provides 24-hour-a-day nursing *services* under the direction of a R.N. and has a full-time administrator.

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

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

HOME HEALTH CARE

Expenses incurred for home health care are payable as shown on the Schedule of Benefits. The maximum weekly benefit for such coverage may not exceed the maximum allowable weekly cost for care in a skilled nursing facility.

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

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

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

1. Hospitalization or *confinement* in a skilled nursing facility would otherwise be required if home care were not provided;

2. Necessary care and treatment are not available from a *family member* or other persons residing with *you*; and

3. The home health care *services* will be provided or coordinated by a state-licensed or *Medicare*-certified *home health agency* or certified rehabilitation agency.

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

The home health care plan consists of:

1. Care by or under the supervision of a registered nurse (R.N.);

2. Physical, speech, occupational, cognitive and respiratory therapy and home health aide *services*; and

3. Medical supplies, laboratory *services* and nutritional counseling, if such *services* and supplies would have been covered if *you* were *hospital confined*.

Home health care benefits do not include:

1. Charges for mileage or travel time to and from the *covered person's* home;

2. Wage or shift differentials for home health care *providers*;

3. Charges for supervision of home health care *providers*;

4. Private duty nursing;

5. *Durable medical equipment* and prosthetics.

DURABLE MEDICAL EQUIPMENT (DME)

Durable medical equipment (DME) is payable as shown on the Schedule of Benefits and includes *DME* provided within a *covered person's* home. Rental is allowed up to, but not to exceed, the purchase price of the *durable medical equipment (DME)*. This *Plan*, at its option, may authorize the purchase of *DME* in lieu of its rental, if the rental price is projected to exceed the purchase price. Oxygen and rental of equipment for its administration and insulin infusion pumps in the treatment of diabetes are considered *DME*. Repair or maintenance of *DME* and duplicate *DME* is not covered.

Prosthetics

Initial prosthetic devices or supplies, including but not limited to, limbs and eyes are payable as shown on the Schedule of Benefits. Coverage will be provided for prosthetic devices necessary to restore minimal basic function. Replacement is a *covered expense* if due to pathological changes. Repair or maintenance of prosthetics is not covered, unless the manufacturer does not cover the repair. Coverage for penile prosthetics/implants are excluded, unless the penile implant is for reconstruction *services* related to penile trauma or amputation, or after prostate, bladder, bowel or spinal surgery.

AMBULANCE

Local professional ground or air *ambulance* service to the nearest *hospital* equipped to provide the necessary treatment is covered as shown on the Schedule of Benefits. *Ambulance* service must not be provided primarily for the convenience of the patient or the *qualified practitioner*.

Ambulance service providing local transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured:

1. From a *covered person's* home or scene of *accident* or medical *emergency* to the closest facility that can provide *covered services* appropriate to the *covered person's* condition. If there is no facility in the local area that can provide *covered services* appropriate to the *covered person's* condition, *ambulance service* means transportation to the closest facility outside the local area that can provide the necessary *services*;

2. Between *hospitals*; and

3. Between a *hospital* and *nursing facility*, with prior approval of the *Plan*.

When approved by the *Plan*, *ambulance* service providing local transportation by means of a specially designed vehicle used only for transporting the sick and injured:

1. From a *hospital* to the *covered person's* home; or

2. From a *nursing facility* to the *covered person's* home when the transportation to the facility would qualify as a *covered service*.

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

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

MORBID OBESITY

Morbid obesity services are payable as shown on the Schedule of Benefits section.

TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ)

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

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

1. Diagnostic examination;

2. Diagnostic x-rays;

3. Injection of muscle relaxants;

4. Therapeutic drug injections;

5. Physical therapy;

6. Diathermy therapy;

7. Ultrasound therapy;

8. Splint therapy; and

9. Arthrocentesis and aspiration.

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

1. Any appliance or the adjustment of any appliance involving orthodontics;

2. Any electronic diagnostic modalities;

3. Occlusal analysis; and

4. Muscle testing.

DENTAL INJURY

Dental injury services are payable as shown on the Schedule of Benefits and include charges for *services* for the treatment of a *dental injury* to a *sound natural tooth*, including but not limited to extraction and initial replacement.

Services for teeth injured as a result of chewing are not covered.

The *dental injury* shall be of sufficient significance that initial contact for evaluation shall occur within 72 hours after the *dental injury*. *Services* must begin within 90 days and be completed within 12 months after the date of the *dental injury*.

Benefits will be paid only for *expenses incurred* for the least expensive *service* that will produce a professionally adequate result as determined by this *Plan*.

THERAPY SERVICES

Therapy services are payable as shown on the Schedule of Benefits.

Chiropractic Care

Chiropractic care for the treatment of a *bodily injury* or *sickness* is payable as shown on the Schedule of Benefits. *Maintenance care* is not covered.

TRANSPLANT SERVICES

This *Plan* will pay benefits for the expense of a transplant as defined below for a *covered person* when approved in advance by Humana, subject to those terms, conditions and limitations described below and contained in this *Plan*. Please call the customer service phone number listed on the back of *your* ID card when in need of these *services*.

Covered Organ Transplant

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

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

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

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

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

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

Exclusions

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

1. It is *experimental, investigational or for research purposes* as defined in the Definitions section;

2. Humana is not contacted for authorization prior to referral for evaluation of the transplant;

3. Humana does not approve coverage for the transplant, based on its established criteria;

4. Expenses are eligible to be paid under any private or public research fund, government program, except Medicaid, or another funding program, whether or not such funding was applied for or received;

5. The expense relates to the transplantation of any non-human organ or tissue, unless otherwise stated in this *Plan*;

6. The expense relates to the donation or acquisition of an organ for a recipient who is not covered by this *Plan*;

7. A denied transplant is performed; this includes the pre-transplant evaluation, pre-transplant *services*, the transplant procedure, post-discharge *services*, immunosuppressive drugs and complications of such transplant;

8. The *covered person* for whom a transplant is requested has not met pre-transplant criteria as established by Humana.

Covered Services

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

1. *Hospital* and *qualified practitioner services*, payable as shown on the Schedule of Benefits. If *services* are rendered at a Humana National Transplant Network (NTN) facility, *covered expenses* are paid in accordance to the NTN contracted rates;

2. Organ acquisition and donor costs. Except for bone marrow transplants, donor costs are not payable under this *Plan* if they are payable in whole or in part by any other group plan, insurance company, organization or person other than the donor's family or estate. Coverage for bone marrow transplants procedures will include costs associated with the donor-patient to the same extent and limitations associated with the *covered person;*

3. Direct, non-medical costs for the *covered person* will be paid as shown on the Schedule of Benefits, for: (a) transportation to and from the *hospital* where the transplant is performed; and (b) temporary lodging at a prearranged location when requested by the *hospital* and approved by Humana. These direct, non-medical costs are only available if the *covered person* lives more than 100 miles from the transplant facility;

4. Direct, non-medical costs for one support person of the *covered person* (two persons if the patient is under age 18 years) will be paid as shown on the Schedule of Benefits, for: (a) transportation to and from the approved facility where the transplant is performed; and (b) temporary lodging at a prearranged location during the *covered person's confinement* in the *hospital*. These direct, non-medical costs are only available if the *covered person's* support person(s) live more than 100 miles from the transplant facility.

BEHAVIORAL HEALTH SERVICES

Expense incurred by *you* during a plan of treatment for *behavioral health* is payable as shown on the Schedule of Benefits for:

1. Charges made by a *qualified practitioner*;

2. Charges made by a *hospital*;

3. Charges made by a *qualified treatment facility*;

4. Charges for x-ray and laboratory expenses.

Inpatient Services

Covered expenses while *confined* as a registered bed patient in a *hospital* or *qualified treatment facility* are payable as shown on the Schedule of Benefits.

Outpatient Services

Covered expenses for *outpatient* treatment received while not *confined* in a *hospital* or *qualified treatment facility* are payable as shown on the Schedule of Benefits.

Autism Services

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

Covered expenses for *autism* benefits do not aggregate toward the *out-of-pocket limits* described on the Schedule of Benefits.

Autism benefits are for rehabilitative, therapeutic and *respite care services*. Rehabilitative and therapeutic *services* are subject to review for *medical necessity* up to the benefit limit. There is a $50,000 annual maximum for children 1 through 6 years of age and a $1,000 monthly benefit for children 7 through 21 years of age, which will not be subject to review for *medical necessity*. This benefit shall not apply to other health or *mental health conditions* which are not related to the treatment of *autism*. Respite care has a separate monthly benefit allowance of $375.

Kentucky Employee Assistance Program (KEAP)

Your employer offers a Kentucky Employee Assistance Program (KEAP) for treatment of *behavioral health* for *you* or *your* covered *dependents*. For more information, contact the Kentucky Employee Assistance Program at:

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

Limitations

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

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

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

OTHER COVERED EXPENSES

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

1. Blood and blood plasma are payable as long as it is NOT replaced by donation, and administration of blood and blood products including blood extracts or derivatives;

2. Casts, trusses, crutches, *orthotics*, splints and braces. *Orthotics* must be custom made or custom fitted, made of rigid or semi-rigid material. Oral or dental splints and appliances must be custom made and for the treatment of documented obstructive sleep apnea. Unless specifically stated otherwise, fabric supports, replacement *orthotics* and braces, oral splints and appliances, dental splints and appliances, and dental braces are not a *covered expense*;

3. Reconstructive *surgery* due to *bodily injury*, infection or other disease of the involved part or congenital disease or anomaly of a covered *dependent* child which resulted in a *functional impairment*;

4. Reconstructive *services* following a covered mastectomy, including but not limited to:
   a. Reconstruction of the breast on which the mastectomy was performed;
   b. Reconstruction of the other breast to achieve symmetry;
   c. Prosthesis; and
   d. Treatment of physical complications of all stages of the mastectomy, including lymphedemas;

5. *Telehealth* Consultation *services*. Covered *services* include a medical or health consultation for purposes of patient diagnosis or treatment that requires the use of advanced telecommunications technology, including, but not limited to: (a) compressed digital interactive video, audio, or data transmission; and (b) clinical data transmission via computer imaging for teleradiology or telephathology; and (c) other technology that facilitates access to other covered health care *services* or medical specialty expertise;

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

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

7. Immunizations in accordance with recommendations of the Advisory Council on Immunization Practices of the Centers for Disease Control and Prevention and Therapeutic injections;

8. Audiometric *services* covered only in conjunction with a disease, *sickness* or injury;

9. Cochlear implants;

10. Therapy and testing for treatment of allergies, including but not limited to, skin titration (Rinkel Test), cytotoxicity testing (Bryan's Test), urine auto injection, provocative and neutralization testing for allergies, or for an assessment of IgG antibodies in food allergies, *services* related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts, neutralization test and/or treatment UNLESS such therapy or testing is NOT approved by:

    a. The American Academy of Allergy and Immunology, or
    b. The Department of Health and Human Services or any of its offices or agencies;

11. Routine costs associated with clinical trials, when approved by this *Plan*. For additional details, go to www.humana.com, click on "Humana Websites for Providers" along the left hand side of the page, then click "Medical Coverage Policies" under Critical Topics, then click "Medical Coverage Policies" and search for Clinical Trials.

LIMITATIONS AND EXCLUSIONS

This *Plan* does not provide benefits for:

1. *Services*:
   a. Not furnished by a *qualified practitioner* or *qualified treatment facility*;
   b. Not authorized or prescribed by a *qualified practitioner*;
   c. Not specifically covered by this *Plan* whether or not prescribed by a *qualified practitioner*;
   d. Which are not provided;
   e. For which no charge is made, or for which *you* would not be required to pay if *you* were not covered under this *Plan* unless charges are received from and reimbursable to the United States Government or any of its agencies as required by law;
   f. Furnished by or payable under any plan or law through any government or any political subdivision (this does not include *Medicare* or Medicaid);
   g. Furnished for a military service connected *sickness* or *bodily injury* by or under an agreement with a department or agency of the United States Government, including the Department of Veterans Affairs;
   h. Performed in association with a *service* that is not covered under this *Plan*;
   i. Performed as a result of a complication arising from a *service* that is not covered under this *Plan*.

2. Immunizations required for foreign travel;

3. Radial keratotomy, refractive keratoplasty or any other *surgery* to correct myopia, hyperopia or stigmatic error;

4. *Services* related to gender change;

5. *Cosmetic surgery* and cosmetic *services*, devices or supplies and complications arising directly from the cosmetic *services*, unless for reconstructive *surgery*:
   a. Resulting from a *bodily injury*, infection or other disease of the involved part, when *functional impairment* is present; or
   b. Resulting from a congenital disease or anomaly of a covered *dependent* child which resulted in a *functional impairment*.

   Expense incurred for reconstructive *surgery* performed due to the presence of a psychological condition is not covered, unless the condition(s) described above are also met;

   Cosmetic *services* means *services* and surgical procedures performed to improve a *covered person's* appearance or to correct a deformity without restoring physical bodily function, unless *medically necessary*. The presence of a psychological condition does not make a cosmetic *service medically necessary* and will not entitle a *covered person* to coverage for cosmetic *services*. Examples of exclusions include, but are not limited to, removal of tattoos, scars, wrinkles or excess skin; plastic *surgery*; silicone injections or implants; electrolysis; wigs, including those used as cranial prosthesis; treatment of male pattern baldness; revision of previous elective procedures; keloids; pharmaceutical regimes; nutritional procedures or treatments; rhinoplasty; epikeratophakia *surgery*; skin abrasions which are performed as a treatment for acne; hair removal via laser therapy or any other method

6. Hair prosthesis, hair transplants or hair implants;

7. Dental *services* except as otherwise specifically provided, *services*, supplies, or other care for dental *services* and procedures involving tooth structures, extractions, gingival tissues, alveolar processes, dental x-rays (other than for an accidental injury), procedures of dental origin, odontogenic cysts/tumors, or any orthodontic, or periodontic treatment regardless of *medical necessity*, except that *hospital services* may be covered provided such *services* are pre-certified as *medically necessary* to safeguard the health of the *covered person* from the effects or side effects of a dental procedure due to a specific non-dental organic impairment. *Services* and supplies for maxillary and/or mandibular augmentation/implant procedures to facilitate the use of full or partial dental prosthesis, fixed or removable;

8. *Services* which are:
   a. Rendered in connection with a *mental health* disorder not classified in the International Classification of Diseases of the U.S. Department of Health and Human Services;
   b. Extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation.

9. *Services*, supplies, or other care provided for conditions related to conduct disorders (except attention deficit disorders), pervasive developmental disorders (except *autism)*, behavioral disorders, learning disabilities and disorders, or mental retardation. *Services*, supplies or other care for non-chemical addictions such as gambling, sexual, spending, shopping and working addictions, codependency, or caffeine addition. Milieu therapy, marriage counseling, *inpatient admissions* for environmental change, biofeedback, neuromuscular re-education, hypnotherapy, sleep therapy, vocational rehabilitation, sensory integration, educational therapy and recreational therapy, except for such adjunct *services* as part of the *inpatient* stay and required by the Joint Commission on Accreditation of Healthcare Organizations or the Commission of Accreditation of Rehabilitative Facilities;

10. *Court-ordered mental health* or *substance abuse services*;

11. Education or training, unless otherwise specified in this *Plan*;

12. Educational or vocational therapy, testing, services or schools, including therapeutic boarding schools and other therapeutic environments. Educational or vocational videos, tapes, books and similar materials are also excluded;

13. Expenses for *services* that are primarily and customarily used for environmental control or enhancement (whether or not prescribed by a *qualified practitioner*) and certain medical devices including, but not limited to:
   a. Common household items including air conditioners, humidifiers, dehumidifiers, air purifiers, water purifiers, vacuum cleaners, waterbeds, hypoallergenic mattresses or pillows or exercise and massage equipment;
   b. Motorized transportation equipment (e.g. scooters), escalators, elevators, seat lift chairs, ramps or modifications or additions to living/working quarters or transportation vehicles;
   c. Personal hygiene equipment including bath/shower chairs, transfer equipment or supplies or bed side commodes;
   d. Personal comfort items including cervical pillows, gravity lumbar reduction chairs, swimming pools, whirlpools, spas or saunas;
   e. Medical equipment including blood pressure monitoring devices, breast pumps, PUVA lights and stethoscopes;

f. Communication system, telephone, television or computer systems and related equipment or similar items or equipment;
g. Communication devices, except after surgical removal of the larynx or a diagnosis of permanent lack of function of the larynx;
h. *Durable medical equipment*, prosthesis, or orthotic device having convenience or luxury features which are not *medically necessary*, except that benefits for the cost of standard equipment or device used in the treatment of disease, *sickness*, or injury will be provided toward the cost of any deluxe equipment, prosthetic or device selected;
i. Vehicle adjustments, stair-gliders, *emergency* alert equipment, handrails, heat appliances.

14. Charges for:
    a. Failure to keep a scheduled visit;
    b. Completion of a *claim* form; or
    c. Providing requested information to the *Plan*.

15. Any medical treatment, procedure, drug, biological product or device which is *experimental, investigational or for research purposes*, unless otherwise specified in this *Plan*;

16. *Services* not *medically necessary* for diagnosis and treatment of a *bodily injury* or *sickness*;

17. Charges in excess of the *maximum allowable fee* for the *service*;

18. *Services* provided by a person who ordinarily resides in *your* home or who is a *family member*;

19. Any *expense incurred* prior to *your effective date* under this *Plan* or after the date *your* coverage under this *Plan* terminates, except as specifically described in this *Plan*;

20. *Expenses incurred* for which *you* are entitled to receive benefits under *your* previous dental or medical plan;

21. Any expense due to the *covered person's*:
    a. Engaging in an illegal occupation; or
    b. Commission of or an attempt to commit a criminal act.

22. *Services*, supplies, or other care provided in treatment of injuries sustained or illnesses resulting from participation in a riot or civil disturbance or while committing or attempting to commit an assault or felony. *Services*, supplies or other care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs;

23. Any loss caused by or contributed to:
    a. War or any act of war, whether declared or not;
    b. Insurrection; or
    c. Any act of armed conflict, or any conflict involving armed forces of any authority.

24. Any *expense incurred* for *services* received outside of the United States, except for *emergency* care *services*, unless otherwise determined by this *Plan*;

25. Treatment of nicotine habit or addiction, including, but not limited to hypnosis, smoking cessation products (except as covered and provided through the Pharmacy Benefit Manager), classes or tapes;

26. Food, dietary supplements and dietary formulas (except special formulas *medically necessary* for the treatment of certain inborn errors of metabolism including phenylketonuria (PKU)), minerals, vitamins, or drugs which could be purchased without a written prescription, or are not FDA approved for treatment of a specified category of medical conditions, or are not *medically necessary*, or are considered to be *experimental* or *investigational*, except as provided through the Pharmacy Benefit Manager's Summary Plan Description;

27. *Prescription* drugs and *self-administered injectable drugs*, unless administered to *you*:
    a. While *inpatient* in a *hospital*, *qualified treatment facility* or skilled nursing facility;
    b. By the following, when deemed appropriate by this *Plan*: a *qualified practitioner*, during an office visit, while *outpatient*, or at a home health care agency as part of a covered home health care plan approved by this *Plan*; or
    c. Provided through the Pharmacy Benefit Manager's Summary Plan Description.

28. Any drug prescribed, except:
    a. FDA approved drugs utilized for FDA approved indications; or
    b. FDA approved drugs utilized for *off-label drug indications* recognized in at least one compendia reference or peer-reviewed medical literature deemed acceptable to this *Plan*.

29. *Off-evidence drug indications*;

30. Over-the-counter, non-prescription medications;

31. Growth hormones (medications, drugs or hormones to stimulate growth);

32. Therapy and testing for treatment of allergies including, but not limited to, *services* related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts, neutralization test and/or treatment UNLESS such therapy or testing is approved by:
    a. The American Academy of Allergy and Immunology, or
    b. The Department of Health and Human Services or any of its offices or agencies.

33. Professional pathology or radiology charges, including but not limited to, blood counts, multi-channel testing, and other clinical chemistry tests, when:
    a. The *services* do not require a professional interpretation, or
    b. The *qualified practitioner* did not provide a specific professional interpretation of the test results of the *covered person*.

34. *Services* that are billed incorrectly or billed separately, but are an integral part of another billed *service*;

35. Expenses for health clubs or health spas, aerobic and strength conditioning, work-hardening programs or weight loss or similar programs, and all related material and product for these programs;

36. *Alternative medicine*;

37. *Services* rendered in a premenstrual syndrome clinic or holistic medicine clinic;

38. *Services* of a midwife, unless provided by a Certified Nurse Midwife;

39. The following types of care of the feet:
    a. Shock wave therapy of the feet;
    b. The treatment of weak, strained, flat, unstable or unbalanced feet;
    c. Hygienic care, and the treatment of superficial lesions of the feet, such as corns, calluses or hyperkeratosis;
    d. The treatment of tarsalgia, metatarsalgia, or bunion, except surgically;
    e. The cutting of toenails, except the removal of the nail matrix;
    f. The provision of heel wedges, lifts or shoe inserts; and
    g. The provision of arch supports or orthopedic shoes, unless *medically necessary*.

40. *Custodial care* and *maintenance care*, supplies, or other care rendered by or in: (a) rest homes; (b) health resorts; (c) homes for the aged; (d) places primarily for domiciliary or *custodial care*; and (e) self-help training or other forms of non-medical self-care;

41. Weekend non-emergency *hospital admissions*, specifically *admissions* to a *hospital* on a Friday or Saturday at the convenience of the *covered person* or his or her *qualified practitioner* when there is no cause for an *emergency admission* and the *covered person* receives no *surgery* or therapeutic treatment until the following Monday;

42. *Hospital inpatient services* when *you* are in observation status;

43. *Services* rendered by a standby physician, surgical assistant, assistant surgeon, *physician assistant*, registered nurse or certified operating room technician unless *medically necessary*;

44. *Ambulance services* for routine transportation to, from or between medical facilities and/or a *qualified practitioner's* office. Travel or transportation expenses (except *ambulance*), even though prescribed by a *physician*. Air *ambulance* is excluded, unless *emergency* medical *services*, the attending *physician*, or the *Plan* determines an air *ambulance* is the only medically appropriate means of transportation to the nearest appropriate facility;

45. *Preadmission testing*/procedural testing duplicated during a *hospital confinement*;

46. Lodging accommodations or transportation, unless specifically provided under this *Plan*;

47. Communications or travel time;

48. No benefits will be provided for the following, unless otherwise determined by this *Plan*:
    a. Immunotherapy for recurrent abortion;
    b. Chemonucleolysis;
    c. Biliary lithotripsy;
    d. Home uterine activity monitoring;
    e. Sleep therapy;
    f. Light treatments for Seasonal Affective Disorder (S.A.D.);
    g. Immunotherapy for food allergy;
    h. Prolotherapy;
    i. Cranial banding;
    j. Hyperhidrosis *surgery*;
    k. Lactation therapy; or
    l. Sensory integration therapy.

49. Any *covered expenses* to the extent of any amount received from others for the *bodily injuries* or losses which necessitate such benefits. Without limitation, "amounts received from others" specifically includes, but is not limited to, liability insurance, workers' compensation, uninsured motorists, underinsured motorists, "no-fault" and automobile med-pay payments or recovery from any identifiable fund regardless of whether the *beneficiary* was made whole;

50. *Services*, supplies, or other care to the extent that benefits or reimbursement are available from or provided by any other group coverage, except that the *Plan* will coordinate the payment of benefits under this plan with such other coverage, as permitted by Kentucky Law;

51. Physical exams/immunizations (except as otherwise provided), *services*, supplies, or other care for routine or periodic physical examinations, immunizations, or tests for screening purposes required by third parties, such as for employment, licensing, travel, school (except approved well visits), insurance, marriage, adoption, participation in athletics, or *services* conducted for medical research or examinations required by a court;

52. Surrogate parenting;

53. Work-related health conditions if the *covered person* is eligible for workers' compensation insurance and the condition is determined to be work-related and benefits are payable under workers' compensation insurance;

54. *Pre-existing conditions* to the extent specified in the Definitions section;

55. Routine vision examinations;

56. Routine vision refraction;

57. The purchase, fitting or repair of eyeglass frames and lenses or contact lenses, unless specifically provided under this *Plan*;

58. Vision therapy;

59. Routine hearing examinations;

60. Routine hearing testing or screening, other than the screening of a newborn in the *hospital*;

61. *Hearing aids*, the fitting or repair of *hearing aids* or advice on their care; implantable hearing devices, except for cochlear implants and auditory brain stem implants as determined by this *Plan* or unless specifically provided under this *Plan*;

62. Elective medical or surgical abortion, unless:
    a. The pregnancy would endanger the life of the mother; or
    b. The pregnancy is a result of rape or incest; or
    c. The fetus has been diagnosed with a lethal or otherwise significant abnormality.

63. *Services* for a reversal of sterilization;

64. Birth control pills, except as covered and provided through the Pharmacy Benefit Manager's Summary Plan Description;

65. Private duty nursing;

66. Any treatment:
    a. For obesity, unless qualified as *morbid obesity* or *childhood obesity* and *medically necessary*. See Schedule of Benefits for covered *services*;
    b. For obesity, unless qualified as *morbid obesity* or *childhood obesity* and *medically necessary* for the purpose of treating a *sickness* or *bodily injury* caused by, complicated by, or exacerbated by the obesity.

67. Surgical procedures for the removal of excess fat and/or skin in conjunction with or resulting from weight loss due to obesity, *surgery*, or pregnancy or *services* at a health spa or similar facility. *Services*, supplies, or other care for gastric bubble/gastric balloon procedures, stomach stapling, wiring of the jaw, liposuction and jejunal bypasses. Dietary supplements, diet pills and appetite suppressants;

68. Dental osteotomies;

69. Infertility counseling and treatment *services*;

70. Artificial means to achieve pregnancy or ovulation, including, but not limited to, artificial insemination, in vitro fertilization, spermatogenesis, gamete intra fallopian transfer (GIFT), zygote intra fallopian transfer (ZIFT), tubal ovum transfer, embryo freezing or transfer and sperm banking;

71. *Services* related to the treatment and/or diagnosis of sexual dysfunction/impotence;

72. Penile implants and prosthetics, or any other *services* for the diagnosis or treatment of sexual dysfunction/impotence are not covered unless related to penile trauma or amputation, or unless related to reconstructive *services* related to penile trauma or amputation, or after prostate, bladder, bowel or spinal injury;

73. *Services*, supplies and other care for acupuncture, anesthesia by hypnosis, or anesthesia charges for *services* not covered by this plan;

74. No benefits are payable under this provision for residential treatment *services* or any *services* performed at a *Residential treatment facilities*;

75. Halfway-house *services*;

76. Disposable supplies, normally purchased in an over the counter setting, to an *outpatient* facility including, but not limited to, ace bandages, support hosiery, pressure garments, elastic stockings, and band-aids;

77. Chelation therapy except in the treatment of lead or other heavy metal poisoning;

78. *Services*, supplies, or other care for educational or training procedures used in connection with speech except as otherwise defined in the therapy or hearing *services* section;

79. *Services*, supplies, or other care provided to an *inpatient* solely for cardiac rehabilitation. *Services*, supplies, or other care provided for non-human, artificial, or mechanical hearts or ventricular and/or atrial assist devices used as a heart replacement (when not otherwise provided in conjunction with a human organ transplant) and supportive *services* or devices in connection with such care. This exclusion includes *services* for implantation, removal, and complications;

80. Food, housing, home delivered meals, and homemaker services (such as housekeeping, laundry, shopping and errands). Teaching household routine to members of the *covered person's* family; supervision of a *covered person's* children; and other similar functions. Benefits are not provided for home health care education beyond the normal and customary period for learning. Supportive environmental materials, including hand rails, ramps, telephones, air conditioners and similar items. *Services* or supplies provided by the family of the *covered person* or volunteer *ambulance* associations. Visiting teachers, friendly visitors, vocational guidance, and other counselors. *Services* related to diversional and social activities. *Services* for which there is no cost to the *covered person*;

81. Non-emergency diagnostic *admissions* for inpatients or *admissions* primarily for therapy *services*, unless pre-authorized by the *Plan*;

82. *Services*, supplies, and other care related to suction-assisted lipectomy or diastasis recti repair, including instances when diastasis recti is associated with an umbilical or ventral hernia;

83. *Services*, supplies, or other care to the extent that *Medicare* is the primary payer. The *Plan* will coordinate the payment of benefits under this *plan* with *Medicare*, as permitted by Kentucky and Federal law;

84. *Services* or supplies for *mental health conditions* unless performed by a *physician* or other *provider* who is licensed or certified by the Commonwealth of Kentucky (or a corresponding licensing or certifying authority when the service is provided outside of the Commonwealth). *Services* for *mental health conditions* when provided for purposes of medical, educational, or occupational training. Psychological testing beyond that necessary to establish a diagnosis or beyond that approved by the subcontractor;

85. *Services*, supplies, or other care not meeting a *Plan's plan delivery system rules*;

86. Drugs that can be purchased without a written prescription. Amino acid modified preparations and low-protein modified food products for the treatment of lactose intolerance, protein intolerance, food allergy, food insensitivity, except as provided through the Pharmacy Benefit Manager's Summary Plan Description;

87. Marriage counseling;

88. *Residential treatment facilities*;

89. Halfway-house *services*.

NOTE: These limitations and exclusions apply even if a *qualified practitioner* has performed or prescribed a *medically necessary* procedure, treatment or supply. This does not prevent *your qualified practitioner* from providing or performing the procedure, treatment or supply, however, the procedure, treatment or supply will not be a *covered expense*.

COORDINATION OF BENEFITS

BENEFITS SUBJECT TO THIS PROVISION

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

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

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

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

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

EFFECT ON BENEFITS

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

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

ORDER OF BENEFIT DETERMINATION

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

1. The plan has no coordination of benefits provision;

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

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

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

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

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

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

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

COORDINATION OF BENEFITS WITH MEDICARE

TRICARE AS SECONDARY PAYER

Generally, *TRICARE* is intended to be the secondary payer to health benefit, insurance, and third-party plans. See 10 U.S.C. § 1079(j)(1); 32 CFR §§ 199.8(a) and (b). When *TRICARE* is secondary, a benefit may not be paid under *TRICARE* if a person is enrolled in, or covered by, any other insurance, medical service, or health plan, including any plan offered by a third-party payer, to the extent that the benefit is also a benefit under the other plan. In the case of individuals with health coverage through their current employment, the employer insurance plan shall be the first payer, Medicare shall be the second payer, and *TRICARE* shall be the third payer. For example, if an individual is covered by *TRICARE* and also by an employer-sponsored plan, and a particular treatment or procedure is covered by both, the employer-sponsored plan must pay first.

The *TRICARE* rules prohibit employers from providing financial or other incentives for a *TRICARE* eligible employee not to enroll (or to terminate enrollment) under a health plan that would (in the case of such enrollment) be a primary plan. See 10 U.S.C. § 1097c(a)(1); DoD Reg. § 199.8(d)(6), 75 Fed. Reg. 18051 (Apr. 9, 2010). This plan is compliant with 10 U.S.C. § 1097c and 32 CFR § 199.8.

When an employer employs 100 or more persons, the benefits of this Plan will be payable first for a *covered person* who is under age 65 and eligible for *Medicare*. The benefits of *Medicare* will be payable second.

MEDICARE PART A means the Social Security program that provides hospital insurance benefits.

MEDICARE PART B means the Social Security program that provides medical insurance benefits.

A *covered person* is considered to be eligible for *Medicare* on the earliest date coverage under *Medicare* could become effective for him or her.

OPTIONS

Federal Law allows this Plan's actively working covered *employees* age 65 or older and their covered spouses who are eligible for *Medicare* to choose one of the following options:

OPTION 1 - The benefits of this Plan will be payable first and the benefits of *Medicare* will be payable second.

OPTION 2 - *Medicare* benefits only. The *covered person* and his or her *dependents*, if any, will not be covered by this Plan.

Each covered *employee* and each covered spouse will be provided with the choice to elect one of these options at least one month before the covered *employee* or the covered spouse becomes age 65. All new covered *employees* and newly covered spouses age 65 or older will also be offered these options. If Option 1 is chosen, its issue is subject to the same requirements as for a covered *employee* or *dependent* who is under age 65.

Under Federal law, there are two categories of persons eligible for *Medicare*. The calculation and payments of benefits by this Plan differs for each category.

CATEGORY 1 - *Medicare* Eligibles are actively working covered *employees* age 65 or older and their age 65 or older covered spouses, and age 65 or older covered spouses of actively working covered *employees* who are under age 65.

CATEGORY 2 - *Medicare* Eligibles are any other *covered persons* entitled to *Medicare*, whether or not they enrolled for it. This category includes, but is not limited to, retired covered *employees* and their spouses or covered *dependents* of a covered *employee* other than his or her spouse.

CALCULATION AND PAYMENT OF BENEFITS

For *covered persons* in Category 1, benefits are payable by this Plan without regard to any benefits payable by *Medicare*. *Medicare* will then determine its benefits.

For *covered persons* in Category 2, *Medicare* benefits are payable before any benefits are payable by this Plan. The benefits of this Plan will then be reduced by the full amount of all *Medicare* benefits the *covered person* received

RIGHT OF RECOVERY

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

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

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

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

CLAIM PROCEDURES

SUBMITTING A CLAIM

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

- A *claim* must be filed with Humana in writing and delivered to Humana by mail, postage prepaid, or by e-mail. However, a submission to obtain pre-authorization may also be filed with Humana by telephone;

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

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

- *Claims* submissions must be timely. *Claims* must be filed as soon as reasonably possible after they are incurred, and in no event later than 15 months after the date of loss, except if *you* were legally incapacitated. *Plan* benefits are only available for *claims* that are incurred by a *covered person* during the period that he or she is covered under this *Plan*;

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

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

Mail medical *claims* and correspondence to:

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

MISCELLANEOUS MEDICAL CHARGES

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

PROCEDURAL DEFECTS

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

ASSIGNMENTS AND REPRESENTATIVES

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

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

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

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

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

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

CLAIMS DECISIONS

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

Pre-Service Claims

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

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

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

Urgent Care Claims

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

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

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

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

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

    1. This *Plan's* receipt of the specified information; or

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

Concurrent Care Decisions

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

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

Post-Service Claims

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

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

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

TIMES FOR DECISIONS

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

PAYMENT OF CLAIMS

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

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

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

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

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

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

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

INITIAL DENIAL NOTICES

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

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

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

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

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

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

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

APPEALS / GRIEVANCES

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

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

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

Who Should Perform the Appeal?

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

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

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

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

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

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

Internal Appeal

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

- *Member's* name and patient's name.
- The *member's* Kentucky Employees Health Plan Identification Number (found on the *member's* health insurance card).
- The *member's* address and daytime phone number.

- The initial denial letter.
- The *service* being denied. Include all facts and issues related to the denial, including the names of *providers* involved and medical records.

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

Humana will notify the *member* of the internal appeal decision within thirty (30) calendar days of receipt of the internal appeal request.

Expedited Appeal

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

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

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

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

How to file an External Appeal– Adverse Determination

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

Adverse Determinations

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

The external appeal must be requested by the *member*, authorized person or *provider* acting on behalf of and with the consent of the *member* within sixty (60) days after receipt of the internal appeal decision letter. The *member* must have completed the internal appeal process, or Humana must have failed to make a timely determination or notification. In addition, the *member* must have been eligible on the date of *service*, or enrolled and eligible to receive covered benefits under the health benefit plan on the date the service was requested and the treatment or *service* must cost the *member* at least $100 if the *member* did not have insurance.

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

The request for an external review must be submitted to the address as listed on page 81. The request must include consent for Humana to release all necessary medical records to the IRE. The IRE must render a decision within twenty-one (21) calendar days of receipt of the information required from Humana. An extension is available to the IRE if both the *member* and Humana agree in advance.

Expedited External Appeal

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

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

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

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

Coverage Denials

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

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

RIGHT TO REQUIRE MEDICAL EXAMINATIONS

(Applies only to medical plans)

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

EXHAUSTION

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

LEGAL ACTIONS AND LIMITATIONS

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

QUALITY IMPROVEMENT

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

SECTION 3

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

OPEN ENROLLMENT

Once annually *you* will have a choice of enrolling *yourself* and *your* eligible *dependents* in this *Plan*. *You* will be notified in advance when the Open Enrollment Period is to begin and how long it will last. If *you* initially declined coverage for *yourself* or *your dependents* at the time *you* were initially eligible for coverage, *you* will be able to enroll *yourself* and/or *your* eligible *dependents* during the Open Enrollment Period. *Your* coverage, if *you* are age 19 or older, will be subject to the *pre-existing condition* limitation.

EMPLOYEE ELIGIBILITY

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

1. *You* are an *employee* or *retiree* who meets the eligibility requirements of the *employer*; and

2. *You* participate in a state-sponsored retirement system; or

3. *You* are a School Board Member as defined in KRS 18A.225.

Your eligibility date is as determined by the *Plan Sponsor* (Commonwealth of Kentucky).

EMPLOYEE EFFECTIVE DATE OF COVERAGE

You must enroll in a manner acceptable to the *Plan Sponsor* (Commonwealth of Kentucky).

1. If *your* completed enrollment forms are signed by *you* within 35 days after *your* hire date, *your* coverage is effective on the 1st day of the 2nd month following the month of hire. *Your* coverage may be effective at a later date as determined by the *Plan Sponsor* (Commonwealth of Kentucky). Please note: Until April 1, 2011 (due to system changes), enrollment forms signed on the 31st through the 35th day after your hire date, must be sent through your Insurance Coordinator for approval by the Department of Employee Insurance.

2. If *your* completed enrollment forms are signed by *you* more than 35 days after *your* hire date, *you* are a *late applicant* and *you* will not be eligible for coverage under this *Plan* until the next annual Open Enrollment Period or until *you* experience a permitted *qualifying event*. *Your* coverage is effective as determined by the *Plan Sponsor* (Commonwealth of Kentucky).

DEPENDENT ELIGIBILITY

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

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

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

Each *dependent* is <u>eligible</u> for coverage on:

1. The date the *employee* is eligible for coverage, if he or she has *dependents* who may be covered on that date; or

2. The date of birth of the *employee's* natural-born child; or

3. The date a child is placed for adoption under the *employee's* legal guardianship, or the date which the *employee* incurs a legal obligation for total or partial support in anticipation of adoption; or

4. The date a covered *employee's* child is determined to be eligible as an alternate recipient under the terms of a medical child support order.

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

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

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

DEPENDENT EFFECTIVE DATE OF COVERAGE

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

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

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

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

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

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

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

1. If the completed enrollment forms are signed by *you* within 35 days after the newborn *dependent's,* the newly adopted *dependent's,* or the newly placed for adoption *dependent's* eligibility date, that newborn *dependent* and other *dependents* are covered on the date he or she is eligible.

2. If the completed enrollment forms are signed by *you* more than 35 days after the newborn *dependent's* eligibility date, the newborn *dependent* and other *dependents* are a *late applicant*. The newborn *dependent* and other *dependents* will not be eligible for coverage under this *Plan* until the next annual Open Enrollment Period.

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

1. If the completed enrollment forms are signed by *you* within 35 days after the *qualifying event* that *dependent* is covered on the coverage *effective date* as set forth in the *qualifying events* in Exhibit A at the end of this document.

2. If the completed enrollment forms are signed by *you* more than 35 days after the *dependent's* eligibility date, the *dependent* is a *late applicant*. The *dependent* will not be eligible for coverage under this *Plan* until the next annual Open Enrollment Period. The *dependent* is covered as determined by the *employer*.

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

A *dependent* child age 19 through the age of 25 who becomes eligible for other group coverage through full-time employment is no longer eligible for coverage under this Plan

FAMILY CROSS-REFERENCE PAYMENT OPTION

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

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

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

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

TERMINATING THE FAMILY CROSS-REFERENCE PAYMENT OPTION

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

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

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

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

MEDICAL CHILD SUPPORT ORDERS

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

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

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

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

PRE-EXISTING CONDITION LIMITATION

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

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

1. Notify *you* in writing of the existence and terms of any *pre-existing condition* limitation;

2. Notify *you* of *your* right to request a certificate of *creditable coverage* from any applicable prior plans;

3. Notify *you* of *your* right to submit evidence of *creditable coverage* to Humana to reduce the length of any *pre-existing condition* limitation; and

4. Offer to request a certificate of prior *creditable coverage* on *your* behalf.

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

1. Notify *you* in writing of its determination;

2. Notify *you* of the source and substance of any information on which it relied; and

3. Provide an explanation of appeal procedures and allow a reasonable opportunity to submit additional evidence of *creditable coverage*.

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

1. Notifies *you* of such reconsideration in writing disclosing its determination;

2. Notifies *you* with the source and substance of any information on which it relied; and

3. Provides an explanation of appeal procedures and allows a reasonable opportunity to submit additional evidence of *creditable coverage*.

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

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

1. pregnancy;

2. genetic information in the absence of diagnosis;

3. domestic violence; or

4. newborn children, or children adopted before the age of 18, if they are enrolled under the *Plan* within 60 days of the date of birth, the date the child is legally adopted, or the date the child is legally placed for adoption (or 35 days, if other *dependents* are also being enrolled).

5. Effective as of January 1, 2011, this plan will not impose any *pre-existing conditions* on individuals enrolled in the plan who are under 19 years of age (this includes both *employees* who may themselves be under 19 years of age and *dependents* of *employees* under age 19).

SPECIAL PROVISIONS

If *your employer* continues to pay required contributions and does not terminate the Plan, *your* coverage will remain in force for a period of time as determined by *your employer* for a layoff, during an approved medical leave of absence, during a period of *total disability*, during an approved non-medical leave of absence, during an approved military leave of absence or during part-time status.

TERMINATING EMPLOYMENT

KEHP is a current pay health insurance plan. If you leave employment between the 1st and the 15th of the month, your health insurance coverage will terminate on the 15th of the same month. If you leave employment between the 16th and the end of the month, your health insurance coverage will terminate on the last day of the same month.

REINSTATEMENT OF COVERAGE

If *your* coverage under this *Plan* was terminated after a period of layoff, *total disability*, approved medical leave of absence, approved non-medical leave of absence or during part-time status and *you* are now returning to work, *your* coverage is effective as determined by *your employer*. The eligibility period requirement with respect to the reinstatement of *your* coverage will be determined by *your employer*. The *pre-existing condition* limitation will apply if there is a 63-day lapse in coverage.

If *your* coverage under this *Plan* was terminated after an approved military leave of absence (other than USERRA) or during part-time status and *you* are now returning to work, *your* coverage is effective as determined by *your employer*. The eligibility period requirement with respect to the reinstatement of *your* coverage will be determined by *your employer*. The *pre-existing condition* limitation will be waived.

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

FAMILY AND MEDICAL LEAVE ACT (FMLA)

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

EXTENDED BENEFITS

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

1. Until coverage for the *total disability* has been obtained under another group policy; or

2. The date *your* physician certifies *you* are no longer *totally disabled*; or

3. The date *you* receive benefits equal to any *maximum benefit* shown on the Schedule of Benefits; or

4. The end of twelve consecutive months immediately following the date of *your* termination of coverage. This period of time is measured from the date *your* coverage is terminated under this *Plan*, to the same calendar day of the next succeeding months.

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

RETIREE COVERAGE

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

SURVIVORSHIP COVERAGE

If the *employee* dies while *dependent* coverage is in force, the surviving *dependent spouse* and *dependent children* may continue to be covered through the COBRA provision.

SPECIAL ENROLLMENT

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

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

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

2. Employer contributions towards the other coverage have been terminated. Employer contributions include contributions by any current or former employer (of the individual or another person) that was contributing to coverage for the individual.

3. COBRA coverage under the other plan has since been exhausted.

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

1. Marriage;

2. Birth;

3. Adoption or placement for adoption;

4. Loss of eligibility due to termination of Medicaid or State Children's Health Insurance Program (SCHIP) coverage; or

5. Eligibility for *premium* assistance subsidy under Medicaid or SCHIP.

You may elect coverage under this *Plan* provided enrollment is within 35 days, 60 days from such event as identified in #4 and #5 above from the *qualifying event* or as listed in the Dependent Effective Date of Coverage section. *You* may be required to provide proof that the *qualifying event* has occurred due to one of the reasons listed before coverage under this *Plan* will be effective. Coverage under this *Plan* will be effective the 1st day of the month following the signature date of the enrollment form, but not before the event occurs, unless otherwise specified in this section.

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

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

If *you* become eligible for coverage under this *Plan* through the special enrollment provision, benefits under this *Plan* will be subject to the *pre-existing condition* limitation as defined within the Definitions section if *you* are age 19 or older.

If *you* apply more than 35 days after a *qualifying event*, 60 days from such event as identified in #4 and #5 above or as listed in the Dependent Effective Date of Coverage section, *you* are considered a *late applicant* and will not be eligible for coverage under this *Plan* until the next annual Open Enrollment Period.

Please see *your employer* for more details.

COVERAGE TERMINATION DUE TO PLAN CHANGE

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

1. If a covered *member* is hospitalized when coverage would normally terminate, the prior Insurance Carrier that covered the *member's* hospitalization during the previous plan year would continue coverage until the *member* is released from the *hospital* or transferred to another facility. At the time the *member* is released from the *hospital* or transferred to a new facility, the succeeding Insurance Carrier will assume responsibility for that *member*. It is the *member's* responsibility to ensure that a transfer or re-hospitalization is to a participating facility in compliance with all *Plan* delivery rules.

2. If a *member* has *family coverage* and a covered *dependent* is hospitalized when coverage would normally terminate due to a change in Insurance Carriers, the hospitalized family member would continue his/her prior coverage until discharge from the *hospital* or transfer to another facility. All other covered *dependents* not hospitalized at the date the new coverage begins would be transferred to the new *Plan* on the date the new coverage starts (not on the date the hospitalized *dependent* is released or transferred).

3. If a covered *member* is not at work and/or is on unofficial leave without pay or otherwise continuing to pay for his/her own health insurance *premiums* on the group coverage, that participant will begin coverage with his/her succeeding Insurance Carrier on January 1, even though he/she is not at work.

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

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

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

TERMINATION OF COVERAGE

Coverage terminates on the earliest of the following:

1. The date this *Plan* terminates;

2. The end of the period for which any required contribution was due and not paid;

3. As determined by *your employer* when *you* enter full-time military, naval or air service, except coverage may continue during an approved military leave of absence as indicated in the Special Provisions;

4. The date determined by *your employer*, when *you* fail to be in an *eligible class* of persons according to the eligibility requirements of the *employer*;

5. For all *employees*, as determined by *your employer*, following termination of employment with the *employer*;

6. The date determined by *your employer you* request termination of coverage to be effective for yourself based on valid *qualifying event* guidelines;

7. For any benefit, the date the benefit is removed from this *Plan*;

8. For *your dependents*, the date *your* coverage terminates;

9. For a *dependent*, the date determined by *your employer* the *dependent* enters full-time military, naval or air service;

10. For a *dependent*, the date determined by *your employer* such *covered person* no longer meets the definition of *dependent*; or

11. The date determined by *your employer you* request termination of coverage to be effective for *your dependents* based on valid *qualifying event* guidelines.

If *you* or any of *your* covered *dependents* no longer meet the eligibility requirements, *you* and *your employer* are responsible for notifying Humana of the change in status. Coverage will not continue beyond the end of the month in which eligibility ends even if notice has not been given to Humana, *employer*, or *Plan Sponsor* (Commonwealth of Kentucky).

SECTION 4

GENERAL PROVISIONS AND REIMBURSEMENT/ SUBROGATION

GENERAL PROVISIONS

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

PLAN ADMINISTRATION

The *Plan Sponsor* (Commonwealth of Kentucky) has established and continues to maintain this *Plan* for the benefit of its *employees* and their eligible *dependents* as provided in this document.

Benefits under this *Plan* are provided on a self-insured basis, which means that payment for benefits is ultimately the sole financial responsibility of the *Plan Sponsor* (Commonwealth of Kentucky). Certain administrative services with respect to this *Plan*, such as *claims* processing, are provided under a services agreement. Humana is not responsible, nor will it assume responsibility, for benefits payable under this *Plan*.

Any changes to this *Plan*, as presented in this *Summary Plan Description*, must be properly adopted by the *Plan Sponsor* (Commonwealth of Kentucky), and material modifications must be timely disclosed in writing and included in or attached to this document. A verbal modification of this *Plan* or promise having the same effect made by any person will not be binding with respect to this *Plan*.

RESCISSION

This Plan will rescind coverage only due to fraud or an intentional misrepresentation of a material fact. Rescission is a cancellation or discontinuance of coverage that has a retroactive effect. A cancellation or discontinuance is not a rescission if the cancellation or discontinuance of coverage has only a prospective effect, or the cancellation or discontinuance of coverage is effective retroactively, to the extent it is attributable to a failure to timely pay premium or costs of coverage.

CONTESTABILITY

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

RIGHT TO REQUEST OVERPAYMENTS

This *Plan* reserves the right to recover any payments made by this *Plan* that were:

1. Made in error; or

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

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

TIME LIMIT ON CERTAIN DEFENSES

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

WORKERS' COMPENSATION NOT AFFECTED

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

WORKERS' COMPENSATION

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

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

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

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

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

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

MEDICAID

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

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

CONSTRUCTION OF PLAN TERMS

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

REIMBURSEMENT/SUBROGATION

RIGHT OF RECOVERY

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

SUBROGATION

This *Plan* reserves all rights of subrogation. This means that the *Plan* has the right to recover its previously paid benefit payments from any award, settlement, or damages that *you* or *your dependent* may receive or to which *you* may become entitled. It also means that the *Plan* has the right to take action on *your* behalf to obtain an award, settlement, or damages. The *Plan* shall have the first lien upon all awards, settlements, or damages subject to its subrogation or reimbursement rights listed below. This lien shall be in the amount of benefits provided or the amount of benefits that will be provided under the *Plan*, plus the reasonable expenses, including attorneys' fees, to enforce the *Plan's* rights.

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

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

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

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

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

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

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

PLAN'S RIGHT TO ASSERT CLAIMS ON YOUR BEHALF

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

MISCELLANEOUS SUBROGATION

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

DUTY TO COOPERATE

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

RETENTION OF AN ATTORNEY

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

PARTICIPANT'S NONCOMPLIANCE

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

RIGHT TO COLLECT NEEDED INFORMATION

You must cooperate with Humana and when asked, assist Humana by:

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

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

REIMBURSEMENT/SUBROGATION EXCLUSIONS

Any *covered expenses* to the extent of any amount received from others for the *bodily injuries* or losses which necessitate such benefits. Without limitation, "amounts received from others" specifically includes, but is not limited to, liability insurance, worker's compensation, uninsured motorists, underinsured motorists, "no-fault" and automobile med-pay payments or recovery from any identifiable fund regardless of whether the *beneficiary* was made whole.

SECTION 5

NOTICES

IMPORTANT NOTICES FOR EMPLOYEES AND SPOUSES AGE 65 AND OVER

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

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

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

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

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

You have the option to reject plan coverage offered by *your employer*, as does any eligible *employee*. If *you* reject coverage under *your employer's Plan*, coverage is terminated and *your employer* is not permitted to offer *you* coverage that supplements *Medicare covered services*. This includes any *Medicare* Supplement coverage that may be available to *you* as a result of *your* retirement through a Kentucky Retirement System.

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

If a *Medicare* eligible *employee* is re-employed by any agency of the Commonwealth in a position working at least 100 hours per month (or otherwise eligible for benefits pursuant to KRS 18A.225), he or she will be eligible to re-enroll (or to remain enrolled) in the Kentucky Employees' Health Plan. While a *Medicare* eligible retiree is actively employed by the Commonwealth and eligible to participate in the KEHP, federal law provides that he or she is **not eligible** to receive coverage from any Kentucky retirement system (including the Kentucky Retirement System, Judicial/Legislative Retirement, and Kentucky Teachers' Retirement System, etc.) that supplements the *employee's Medicare* coverage. According to federal *Medicare* laws, a health plan must pay primary to *Medicare*. Therefore, any health coverage the *employee* receives from a Kentucky-sponsored program (KEHP) must pay for *Medicare*-covered expenses, up to the limit of his or her coverage under the Kentucky program, before applying to *Medicare* for payment. If an *employee* is currently receiving *Medicare* supplemental coverage from one of the Kentucky retirement system(s), the *employee* should drop this supplemental coverage while he or she is actively employed and eligible to participate in the KEHP.

IMPORTANT NOTICES FOR EMPLOYEES AND SPOUSES AGE 65 AND OVER

If a *Medicare* eligible reemployed *employee* elects KEHP health plan or the "waiver" HRA, it must pay primary (e.g. before) to *Medicare* covered expenses.

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

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

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

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

A *covered person* will be deemed to have consented to use of *protected health information* about him or her for the sole purpose of health care operations by virtue of enrollment in this *Plan*. This *Plan* must obtain authorization from a *covered person* to use *protected health information* for any other purpose.

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

Disclosure of *protected health information* is improper if it is not allowed by law or if it is made for any purpose other than *Plan* operation or benefits delivery without authorization. Disclosure for *Plan* purposes to persons authorized to receive *protected health information* may be proper, so long as the disclosure is allowed by law and appropriate under the circumstances. Improper disclosure includes disclosure to the *employer* for employment purposes, *employee* representatives, consultants, attorneys, relatives, etc. who have not executed appropriate agreements effective to authorize such disclosure.

Humana will afford access to *protected health information* in its possession only as necessary to discharge its obligations as a service *provider*, within the restrictions noted above. Information received by Humana is information received on behalf of this *Plan*.

Humana will afford access to *protected health information* as reasonably directed in writing by the *Plan Administrator*, which shall only be made with due regard for confidentiality. In that regard, Humana has been directed that disclosure of *protected health information* may be made to the person(s) identified by the *Plan Administrator*.

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

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

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

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

Please see the Kentucky Employees' Health Plan Notice of Privacy Practices and HIPAA Privacy and Security Policies for additional information.

CONTINUATION OF MEDICAL BENEFITS

THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1986 (COBRA)

CONTINUATION OF BENEFITS

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

ELIGIBILITY

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

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

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

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

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

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

- The death of the *employee*-parent;
- The termination of the *employee*-parent's employment (for reasons other than gross misconduct, as defined by *your employer*) or reduction in the *employee*-parent's hours of employment with the *employer*;
- The *employee*-parent's divorce or legal separation;

- Ceasing to be a "*dependent* child" under this *Plan*;
- The *employee*-parent becomes entitled to *Medicare* benefits; or
- Termination of the *retiree*-parent's coverage when the former *employer* discontinues *retiree* coverage within one year before or one year after filing for Chapter 11 bankruptcy.

LOSS OF COVERAGE

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

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

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

NOTICES AND ELECTION

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

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

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

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

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

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

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

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

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

MAXIMUM COVERAGE PERIOD

Coverage may continue up to:

- 18 months for an *employee* and/or *dependent* whose group coverage ended due to termination of the *employee's* employment or reduction in hours of employment;

- 36 months for a *spouse* whose coverage ended due to the death of the *employee* or *retiree*, divorce, or the *employee* becoming entitled to *Medicare* at the time of the initial *qualifying event*;

- 36 months for a *dependent* child whose coverage ended due to the divorce of the *employee* parent, the *employee* becoming entitled to *Medicare* at the time of the initial *qualifying event*, the death of the *employee*, or the child ceasing to be a *dependent* under this *Plan*;

- For the *retiree*, until the date of death of the *retiree* who is on continuation due to loss of coverage within one year before or one year after the *employer* filed Chapter 11 bankruptcy.

DISABILITY

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

SECOND QUALIFYING EVENT

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

TERMINATION BEFORE THE END OF MAXIMUM COVERAGE PERIOD

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

- The *employer* no longer provides group health coverage to any of its *employees*;

- The *premium* for continuation is not paid timely;

- The individual on continuation becomes covered under another group health plan (as an *employee* or otherwise); however, if the new plan coverage contains any exclusion or limitation with respect to any *pre-existing condition*, then continuation coverage will end for this reason only after the exclusion or limitation no longer applies or prior *creditable coverage* satisfies the exclusion or limitation;

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

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

TYPE OF COVERAGE; PREMIUM PAYMENT

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

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

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

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

OTHER INFORMATION

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

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

PLAN CONTACT INFORMATION

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

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

COBRA Premium Subsidy Under ARRA

The American Recovery and Reinvestment Act of 2009 (ARRA), as amended by the Continuing Extension Act (CEA), Temporary Extension Act (TEA), and Department of Defense Appropriations Act of 2010 (2010 DoD Act), created rights to COBRA premium assistance *for employees* (and their families) who are involuntarily terminated between **September 1, 2008 and May 31, 2010**. A premium subsidy is available for certain assistance eligible individuals (AEIs) for periods of coverage beginning on or after February 17, 2009—generally March 1, 2009. The AEI pays 35% of the COBRA premium and the *employer* is then reimbursed by the federal government for the other 65% of the COBRA premium, through a credit or refund of an overpayment of payroll taxes. The premium subsidy is available for up to 15 months of the AEI's maximum coverage period. Please contact *your* Insurance Coordinator and Ceridian for more information.

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

CONTINUATION OF BENEFITS

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

ELIGIBILITY

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

An *employee's dependent* who has coverage under this *Plan* immediately prior to the date of the *employee's* covered absence are eligible to elect continuation under USERRA.

PREMIUM PAYMENT

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

DURATION OF COVERAGE

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

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

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

OTHER INFORMATION

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

MEDICAL CONVERSION PRIVILEGE

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

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

1. *Your* coverage ends because *your* employment terminated;

2. *You* are the covered *dependent* former *spouse* or a covered *dependent* child of an *employee* whose marriage ended due to legal annulment, dissolution or divorce;

3. *You* are the surviving *dependent spouse* or child, in the event of the *employee's* death, or at the end of any survivorship continuation provided in the Plan; or

4. *You* have been a covered *dependent* child but no longer meet the definition of *dependent* under the Plan.

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

LIMITATIONS

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

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

DUPLICATION OF COVERAGE

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

ADDITIONAL NOTICES

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA)

If *you* have had or are going to have a mastectomy, *you* may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the covered mastectomy was performed;
- *Surgery* and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

The Newborns' and Mothers' Health Protection Act of 1996 provides that group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending *provider*, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). An attending *provider* is defined as an individual who is licensed under applicable state law to provide maternal or pediatric care and who is directly responsible for providing such care to a mother or newborn child. The definition of attending *provider* does not include a plan, *hospital*, managed care organization or other issuer. In any case, plans may not, under Federal law, require that a *provider* obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

MICHELLE'S LAW

To the extent required by law, this *Plan* is compliant with Michelle's Law, effective January 1, 2010. Under Michelle's Law, this *Plan* must continue to provide coverage to a "dependent child" if the child takes a leave of absence from a postsecondary educational institution, or has a change in enrollment status, that:

- Begins when the student is suffering from a serious injury or illness;
- Is *medically necessary* (as confirmed in a written communication from the student's treating physician); and
- Causes the child to lose student status for purposes of coverage under the *Plan*.

A "*dependent* child" for purposes of Michelle's Law is a child who (1) is a *dependent* child of a participant or beneficiary under the terms of the *Plan*, and (2) was enrolled in the *Plan* on the basis of being a student at a postsecondary educational institution immediately before the medical leave of absence began.

This *Plan* will continue the child's coverage for up to one year after the leave of absence begins or, if earlier, until coverage would have otherwise terminated under the terms of the *Plan*.

MENTAL HEALTH PARITY ACT (MHPA) AND MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008

This *Plan* operates in compliance with Mental Health Parity Act and the Additional Equity Act of 2008 as forth in the Public Health Service Act (PHSA).

THE GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (GINA)

This *Plan* is compliant with Genetic Information Nondiscrimination Act of 2008, Pub. L. No. 110-233 (2008), § 201(2)(B), to be codified at 42 U.S.C. § 2000ff. Section 701(b) of the Civil Rights Act of 1964 is codified at 42 U.S.C. § 2000e(b).

NOTICE ABOUT THE EARLY RETIREE REINSURANCE PROGRAM

You are a plan participant, or are being offered the opportunity to enroll as a plan participant, in an employment based health plan that is certified for participation in the Early Retiree Reinsurance Program. The Early Retiree Reinsurance Program is a Federal program that was established under the Affordable Care Act. Under the Early Retiree Reinsurance Program, the Federal government reimburses a plan sponsor of an employment-based health plan for some of the costs of health care benefits paid on behalf of, or by, early retirees and certain family members of early retirees participating in the employment-based plan. By law, the program expires on January 1, 2014.

Under the Early Retiree Reinsurance Program, your plan sponsor may choose to use any reimbursements it receives from this program to reduce or offset increases in plan participants' premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs. If the plan sponsor chooses to use the Early Retiree Reinsurance Program reimbursements in this way, you, as a plan participant, may experience changes that may be advantageous to you, in your health plan coverage terms and conditions, for so long as the reimbursements under this program are available and this plan sponsor chooses to use the reimbursements for this purpose. A plan sponsor may also use the Early Retiree Reinsurance Program reimbursements to reduce or offset increases in its own costs for maintaining your health benefits coverage, which may increase the likelihood that it

MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free Or Low-Cost Health Coverage To Children And Families

If *you* are eligible for health coverage from *your employer*, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If *you* or *your dependents* are already enrolled in Medicaid or CHIP and *you l*ive in a State listed below, you can contact *your* State Medicaid or CHIP office to find out if premium assistance is available.

If *you* or *your dependents* are NOT currently enrolled in Medicaid or CHIP, and *you* think *you* or any of *your dependents* might be eligible for either of these programs, *you* can contact *your* State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If *you* qualify, *you* can ask the State if it has a program that might help *you* pay the premiums for an employer-sponsored plan.

Once it is determined that *you* or *your dependents* are eligible for premium assistance under Medicaid or CHIP, *your employer's* health plan is required to permit *you* and *your dependents* to enroll in the plan – as long as *you* and *your dependents* are eligible, but not already enrolled in the *employer's* plan. This is called a "special enrollment" opportunity, and ***you* must request coverage within 60 days of being determined eligible for premium assistance**.

If *you* live in one of the following States, *you* may be eligible for assistance paying *your employer* health plan premiums. The following list of States is current as of July 31, 2011. *You* should contact *your* State for further information on eligibility –

ALABAMA – Medicaid	**COLORADO** – Medicaid and CHIP
Website: http://www.medicaid.alabama.gov Phone: 1-800-362-1504	Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943 CHIP Website: http:// www.CHPplus.org CHIP Phone: 303-866-3243
ALASKA – Medicaid	
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	
ARIZONA – CHIP	**FLORIDA** – Medicaid
Website: http://www.azahcccs.gov/applicants/default.aspx Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268

CALIFORNIA – Medicaid	**GEORGIA** – Medicaid
Website: http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-866-298-8443	Website: http://dch.georgia.gov/ Click on Programs, then Medicaid Phone: 1-800-869-1150
IDAHO – Medicaid and CHIP	**MONTANA** – Medicaid
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084
INDIANA – Medicaid	**NEBRASKA** – Medicaid
Website: http://www.in.gov/fssa Phone: 1-800-889-9948	Website: http://www.dhhs.ne.gov/med/medindex.htm Phone: 1-877-255-3092
IOWA – Medicaid	**NEVADA** – Medicaid
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KANSAS – Medicaid	
Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	
KENTUCKY – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: www.dhhs.nh.gov/ombp/index.htm Phone: 603-271-8183

LOUISIANA – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	
Website: http://www.maine.gov/dhhs/OIAS/public-assistance/index.html Phone: 1-800-572-3839	
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK** – Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA** – Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone (Outside of Twin City area): 800-657-3739 Phone (Twin City area): 651-431-2670	Website: http://www.nc.gov Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA** – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
OKLAHOMA – Medicaid and CHIP	**VERMONT**– Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427

OREGON – Medicaid and CHIP	**VIRGINIA** – Medicaid and CHIP
Website: http://www.oregon.gov/OHA/OPHP/FHIAP/index.shtml Phone: 1-888-564-9669	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
PENNSYLVANIA – Medicaid	**WASHINGTON** – Medicaid
Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext. 15473
RHODE ISLAND – Medicaid	**WEST VIRGINIA** – Medicaid
Website: www.dhs.ri.gov Phone: 401-462-5300	Website: www.dhhr.wv.gov/bms/ Phone: 304-558-1700
SOUTH CAROLINA – Medicaid	**WISCONSIN** – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING** – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.health.wyo.gov/healthcarefin/index.html Phone: 307-777-7531
UTAH – Medicaid and CHIP	
Website: http://health.utah.gov/upp Phone: 1-866-435-7414	

To see if any more States have added a premium assistance program since July 31, 2011, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

OMB Control Number 1210-0137 (expires 09/30/2013)

PLAN DESCRIPTION INFORMATION

1. Proper Name of *Plan*: Kentucky Employees' Health Plan

2. *Plan Sponsor*: Commonwealth of Kentucky
Personnel Cabinet, Department of Employee Insurance
501 High Street
Second Floor
Frankfort, KY 40601

3. *Employer*: Commonwealth of Kentucky
Personnel Cabinet, Department of Employee Insurance
501 High Street
Second Floor
Frankfort, KY 40601

Common Name of *Employer*: Commonwealth of Kentucky

4. *Plan Administrator* and Named Fiduciary:

Commonwealth of Kentucky
Personnel Cabinet, Department of Employee Insurance
501 High Street
Second Floor
Frankfort, KY 40601

5. *Employer* Identification Number: 61-0600439

6. This *Plan* provides medical benefits for participating *employees* and their enrolled *dependents*.

7. *Plan* benefits described in this booklet are effective January 1, 2012.

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

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

Commonwealth of Kentucky
Executive Director, Office of Legal Services
501 High Street
Third Floor
Frankfort, KY 40601

10. The *Plan Manager* (Humana) is responsible for performing certain delegated administrative duties, including the processing of *claims*. The *Plan Manager* (Humana) and Claim Fiduciary is:

Humana Insurance Company
500 West Main Street
Louisville, KY 40202
Telephone: Refer to *your* ID card

11. This is a self-insured health benefit *plan*. The cost of this *Plan* is paid with contributions shared by the *employer* and *employee*. Benefits under this *Plan* are provided from the general assets of the *employer* and are used to fund payment of covered *claims* under this *Plan* plus administrative expenses. Please see *your employer* for the method of calculating contributions and the funding mechanism used for the accumulation of assets through which benefits are provided under this *Plan*.

12. Each *employee* of the *employer* who participates in this *Plan* has access to a *Summary Plan Description*, which is this booklet. This booklet will be available through MyHumana.com or http://kehp.ky.gov. It contains information regarding eligibility requirements, termination provisions, a description of the benefits provided and other *Plan* information. Changes can occur to the *Summary Plan Description* throughout the year. Such changes will be posted to the KEHP web site listed above.

13. This *Plan's* benefits and/or contributions may be modified or amended from time to time, or may be terminated at any time by the *Plan Sponsor* (Commonwealth of Kentucky). Significant changes to this *Plan*, including termination, will be communicated to participants as required by applicable law.

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

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

16. This *Plan* is not in lieu of and does not affect any requirement for coverage by workers' compensation insurance.

17. This *Plan* is included in the Commonwealth of Kentucky Flexible Benefits Plan, a Cafeteria Plan created pursuant to the Internal Revenue Code Subsection 125.

SECTION 6

DEFINITIONS

DEFINITIONS

Italicized terms throughout this *SPD* have the meaning indicated below. Defined terms are italicized wherever found in this *SPD*.

A

Accident means a sudden event that results in a *bodily injury* and is exact as to time and place of occurrence.

Admission means entry into a facility as a registered bed patient according to the rules and regulations of that facility. An *admission* ends when *you* are discharged, or released, from the facility and are no longer registered as a bed patient.

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

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

Alternative medicine means an approach to medical diagnosis, treatment or therapy that has been developed or practiced NOT using the generally accepted scientific methods in the United States of America. For purposes of this definition, *alternative medicine* shall include, but is not limited to: acupressure, aromatherapy, ayurveda, biofeedback, faith healing, guided mental imagery, herbal medicine, holistic medicine, homeopathy, hypnosis, macrobiotics, naturopathy, ozone therapy, reflexotherapy, relaxation response, rolfing, shiatsu and yoga.

Ambulance means a professionally operated vehicle, provided by a licensed *ambulance* service, equipped for the transportation of a sick or injured person to or from the nearest medical facility qualified to treat the person's *sickness* or *bodily injury*. Use of the *ambulance* must be *medically necessary* and/or ordered by a *qualified practitioner*.

Ambulatory surgical center means an institution which meets all of the following requirements:

1. It must be staffed by physicians and a medical staff which includes registered nurses;

2. It must have permanent facilities and equipment for the primary purpose of performing *surgery*;

3. It must provide continuous physicians' *services* on an *outpatient* basis;

4. It must admit and discharge patients from the facility within a 24-hour period;

5. It must be licensed in accordance with the laws of the jurisdiction where it is located. It must be operated as an *ambulatory surgical center* as defined by those laws;

6. It must not be used for the primary purpose of terminating pregnancies, or as an office or clinic for the private practice of any physician or dentist.

Autism means a condition affecting a *covered person* ages one (1) through twenty-one (21) years of age, which includes:

(A) A total of six (6) or more items from subparagraphs 1, 2, and 3 of this paragraph, with at least two (2) from subparagraph 1 and one (1) each from subparagraphs 2 and 3:

1. Qualitative impairment in social interaction, as manifested by at least two (2) of the following:
   a. Marked impairment in the use of multiple nonverbal behavior such as eye-to-eye gaze, facial express, body postures, and gestures to regulate social interaction;
   b. Failure to develop peer relationships appropriate to developmental level;
   c. A lack of spontaneous seeking to share enjoyment, interests or achievement with other people; or
   d. Lack of social or emotional reciprocity.

2. Qualitative impairments in communications as manifested by at least one (1) of the following:
   a. Delay in, or total lack of, the development of spoken language;
   b. In individuals with adequate speech, marked impairment in the ability to imitate or sustain a conversation with others;
   c. Stereotyped and repetitive use of language or idiosyncratic language; or
   d. Lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental levels.

3. Restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one (1) of the following:
   a. Encompassing preoccupation with one (1) or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus;
   b. Apparently inflexible adherence to specific, nonfunctional routines or rituals;
   c. Stereotyped and repetitive motor mannerisms; or
   d. Persistent preoccupation with parts or objects.

(B) Delays or abnormal functioning in at least one (1) of the following areas, with onset prior to age three (3) years;

1. Social interaction;

2. Language as used in social communication; or

3. Symbolic or imaginative play; and

(C) The disturbance is not better accounted for by Rett's Disorder or Childhood Disintegrative Disorder.

B

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

Bariatric services means the *bariatric surgery* and the post-discharge *services* and expenses related to complications following an approved *bariatric surgery*.

Bariatric surgery means gastrointestinal *surgery* to promote weight loss for the treatment of *morbid obesity*.

Behavioral health means *mental health services* and *substance abuse services*.

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

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

Bodily injury means bodily damage other than a *sickness*, including all related conditions and recurrent symptoms. However, bodily damage resulting from infection or muscle strain due to athletic or physical activity is considered a *sickness* and not a *bodily injury*.

C

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

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

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

Childhood obesity, for the purpose of this definition, means a child between the ages of 3 and 18 in the 85th percentile or greater of BMI for their age.

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

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

COBRA Service Provider means a *provider* of COBRA administrative services retained by Humana or the *employer* to provide specific COBRA administrative services.

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

Complications of pregnancy means:

1. Conditions whose diagnoses are distinct from pregnancy but adversely affected by pregnancy or caused by pregnancy. Such conditions include: acute nephritis, nephrosis, cardiac decompensation, hyperemesis gravidarum, puerperal infection, toxemia, eclampsia and missed abortion;

2. A nonelective cesarean section surgical procedure;

3. Terminated ectopic pregnancy; or

4. Spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.

Complications of pregnancy does not mean:

1. False labor;

2. Occasional spotting;

3. Prescribed rest during the period of pregnancy;

4. Conditions associated with the management of a difficult pregnancy but which do not constitute distinct *complications of pregnancy*; or

5. An elective cesarean section.

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

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

Confinement or ***confined*** means *you* are admitted as a registered bed patient in a *hospital* or a *qualified treatment facility* as the result of a *qualified practitioner's* recommendation. It does not mean detainment in observation status.

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

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

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

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

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

Court-ordered means involuntary placement in *behavioral health* treatment as a result of a judicial directive.

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

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

Covered expense (or Covered services) means *medically necessary services* incurred by *you* or *your* covered *dependents* for which benefits may be available under this *Plan*, subject to any *maximum benefit* and all other terms, provisions, limitations and exclusions of this *Plan*. A charge for a *covered expense* shall be considered to have been incurred on the date the service or supply was provided.

Covered person means the *member* (*employee, retiree,* COBRA participant) and his/her covered *dependents* enrolled for benefits provided under this *Plan*.

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

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

1. A group health plan, including church and governmental plans;
2. Health insurance coverage;
3. Part A or Part B of Title XVIII of the Social Security Act (*Medicare*);
4. Medicaid, other than coverage consisting solely of benefits under section 1928 of the Social Security Act;
5. The health plan for active and certain former military personnel, including *TRICARE*;
6. The Indian Health Service or other tribal organization program;
7. A state health benefits risk pool;
8. The Federal *Employee*s Health Benefits Program;
9. A public health plan as defined in federal regulations;
10. A health benefit plan under Section 5(e) of the Peace Corps Act;
11. Any other plan which provides comprehensive *hospital*, medical, and surgical *services* and meets federal requirements; and
12. State Children Health Insurance Program (SCHIP).

Creditable coverage does not include any of the following:

1. Accident-only coverage, disability income insurance, or any combination thereof;
2. Supplemental coverage to liability insurance;
3. Liability insurance, including general liability insurance and automobile liability insurance;
4. Workers' compensation or similar insurance;
5. Automobile medical payment insurance;
6. Credit-only insurance;
7. Coverage for on-site medical clinics;

8. Benefits if offered separately:
   a. Limited scope dental and vision;
   b. Long-term care, nursing home care, home health care, community based care, or any combination thereof; and
   c. Other similar, limited benefits.
9. Benefits if offered as independent, non-coordinated benefits:
   a. Specified disease or illness coverage; and
   b. Hospital indemnity or other fixed indemnity insurance.
10. Benefits if offered as a separate policy:
   a. *Medicare* Supplement insurance;
   b. Supplemental coverage to the health plan for active and certain former military personnel, including *TRICARE*; and
   c. Similar supplemental coverage provided to group health plan coverage.

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

D

Deductible, if applicable, means a specified dollar amount of *covered services* that must be satisfied, either individually or combined as a covered family, per *calendar year* before this *Plan* pays benefits for certain specified *services*.

Dental injury means an injury to a *sound natural tooth* caused by a sudden, violent, and external force that could not be predicted in advance and could not be avoided.

Dependent means the following:

1. Spouse -a person of the opposite sex to whom you are legally married.

2. Common Law Spouse - a person of the opposite sex with whom you have established a Common Law union **in a state which recognizes Common Law marriage** (Kentucky does not recognize Common Law Marriage).

3. Child Age 0 to 18 - in the case of a child who has not yet attained his/her 19th birthday, "child" means an individual who is:
   a. A son, daughter, stepson, or stepdaughter of the *employee*/retiree, or
   b. An eligible foster child of the *employee*/retiree (eligible foster child means an individual who is placed with the *employee*/retiree by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction), or
   c. An adopted child of the *employee*/retiree (a legally adopted individual of the *employee*/retiree, or an individual who is lawfully placed with the *employee*/retiree for legal adoption by the *employee*/retiree, shall be treated as a child), or
   d. A grandchild for whom the *employee*/retiree has been awarded guardianship or custody by a court of competent jurisdiction.

4. Child Age 19 to 25 - in the case of a child who has attained his/her 19th birthday but who has not yet attained his/her 26th birthday, "child" means an individual who is:
   a. A son, daughter, stepson, stepdaughter, eligible foster child, adopted child or a grandchild of the employee/retiree – as described above; and
   b. Is NOT eligible to enroll in an employer-sponsored health plan offered by the child's full-time employer.

5. Disabled Dependent - A dependent child who is totally and permanently disabled may be covered on your KEHP benefit plan beyond the end of the month in which he/she turns 26, provided the disability (a) started before his/her 26th birthday and (b) is medically-certified by a physician. A disabled child who was not covered on this Plan prior to his/her 26th birthday may not be enrolled in KEHP unless he/she sustains a specific qualifying event.

PLEASE NOTE:

A Cross Reference Payment Option is a payment option involving two employees/retirees who are a legally married couple and enroll themselves and at least one child as a dependent in a KEHP family plan.

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

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

The KEHP requires documentation to verify a dependent's eligibility before coverage will be provided under the Plan. Examples of such documentation include but are not limited to marriage certificate, birth certificate, court documents and/or guardianship papers.

The health care reform law (Patient Protection and Affordable Care Act) generally requires group health plans that offer dependent coverage to continue making such coverage available for an adult child until age 26 for plan years beginning on January 1, 2011.

The IRS, DOL, and HHS have jointly issued interim final regulations implementing the coverage requirement for adult children. Under these regulations, children who become (or are required to become) eligible to enroll as a result of this requirement must be given written notice of their enrollment right not later than the first day of the plan year. They must be given at least 30 days to enroll, regardless of whether the plan otherwise offers an open enrollment period.

This notice of the eligibility changes was provided via U.S. Mail to all KEHP members in their 2011 Open Enrollment materials. The KEHP 30 day special enrollment period for individuals (whose KEHP coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26) to request enrollment in the KEHP for such children began on October 1st, 2010 and ended on October 31st, 2010.

In general, a dependent under the KEHP for purposes of accident or health coverage is a dependent as defined as in Code § 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof, (2) any child (as defined in Code § 152(f)(1)) of the Participant who as of the end of the taxable year has not attained age 27, and (3) any child of the Participant to whom IRS Rev. Proc. 2008-48 applies (regarding certain children of divorced or separated parents who receive more than half of their support for the calendar year from one or both parents and are in the custody of one or both parents for more than half of the calendar year). Because this plan is "grandfathered" for plan year 2011, this plan is not required to extend coverage to children who are eligible for coverage under another employer's group health plan (*e.g.,* eligible under the plan of the child's own employer). This plan has interpreted this to mean the child full-time employer. A "grandfathered" plan cannot deny coverage if a child is eligible for coverage under another *parent's* group health plan, however.

A "child" is an individual who is the employee's son, daughter, stepson, or stepdaughter, and includes both a legally adopted individual of the employee and an individual lawfully placed with the employee for legal adoption by the employee. The term "child" also includes an eligible foster child, defined as a child placed with the employee by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

The definition change the age limit, residency, support, and other tests that would otherwise have to be met in order for an individual to qualify as a tax dependent under the Code do not apply to such an employee's child for purposes of the tax-favored treatment of health coverage that is available under Code §§ 105(b) and 106.

The status as a "qualifying child" or "qualifying relative" under Section 152 will continue to be relevant when determining the tax treatment of health coverage for individuals who are <u>not</u> an employee's spouse or child.

Individuals under a civil union or domestic partnership are not eligible for coverage under this plan. Dependent status between a Participant and dependent or other individual must not violate federal, state or local law.

Diabetes equipment means blood glucose monitors, including monitors designed to be used by blind individuals, insulin infusion pumps and associated accessories, insulin infusion devices and podiatric appliances for the prevention of complications associated with diabetes.

Diabetes self-management training means the training provided to a *covered person* after the initial diagnosis of diabetes for care and management of the condition including nutritional counseling and use of *diabetes equipment* and supplies. It also includes training when changes are required to the self-management regime and when new techniques and treatments are developed.

Diabetes supplies means test strips for blood glucose monitors, visual reading and urine test strips, lancets and lancet devices, insulin and insulin analogs, injection aids, syringes, prescriptive and nonprescriptive oral agents for controlling blood sugar levels, glucagon emergency kits and alcohol swabs.

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

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

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

E

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

Eligible class means performing on a regular, full-time basis all customary occupational duties, as determined by the *employer*, at the *employer's* business locations or when required to travel for the *employer's* business purposes. An *employee* shall be deemed at work on each day of a regular paid vacation and any regular non-working holiday.

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

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

1. Is the *provider's* usual charge for a given service under the *covered person's* plan;

2. Is within the range of fees charged by *providers* of similar training and experience for the same or similar service or supply within the same or similar limited geographic area; and

3. Does not exceed the fee schedule developed by the carrier for a network *provider*.

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

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

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

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

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

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

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

***Experimental, investigational or for research purposes*:**
Services, supplies, or other care, including treatments, procedures, hospitalizations, drugs, biological products or medical devices, which a Peer Review Panel determines are:

1. Not of proven benefit for the particular diagnosis or treatment of the *covered person's* particular condition;

2. Not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of the *covered person's* particular condition; or

3. Provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

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

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

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

2. Conclusive evidence from the published peer-review medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;

3. Demonstrated evidence as reflected in the published peer-review medical literature must exist that over time the technology leads to improvement in health outcomes, e.g., the beneficial effects outweigh any harmful effects;

4. Proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and

5. Proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph C, are possible in standard conditions of medical practice, outside clinical investigatory settings.

F

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

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

Freestanding renal dialysis facility means a *provider* other than a *hospital* which is primarily engaged in providing renal dialysis treatment, maintenance or training to *outpatients*.

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

Functional impairment means a direct and measurable reduction in physical performance of an organ or body part.

H

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

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

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

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

Hospital means an institution which:

1. Maintains permanent full-time facilities for bed care of resident patients;

2. Has a physician and surgeon in regular attendance;

3. Provides continuous 24 hour a day nursing *services* by, or under the supervision of, registered nurses;

4. Is primarily engaged in providing diagnostic and therapeutic facilities for medical or surgical care of sick or injured persons under the supervision of a staff of fully licensed *physicians*. No *claim* for payment of treatment, care, or *services* shall be denied because a *hospital* lacks major surgical facilities and is primarily of a rehabilitative nature, if such rehabilitation is specifically for treatment of physical disability;

5. Is legally operated in the jurisdiction where located; and

6. Has surgical facilities on its premises or has a contractual agreement for surgical *services* with an institution having a valid license to provide such surgical *services*; or

7. It is a *hospital* accredited by the Joint Commission on the Accreditation of Healthcare Organizations, the American Osteopathic Association, or the Commission on the Accreditation of Rehabilitative Facilities, or certified by the Kentucky Division of Licensure and Regulation.

Hospital does not include an institution which is principally a rest home, skilled nursing facility, convalescent home or home for the aged. *Hospital* does not include a place principally for the treatment of *mental health* or *substance abuse*.

I

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

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

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

Intensive outpatient means *outpatient services* providing:

1. Group therapeutic sessions greater than one hour a day, three days a week;

2. *Behavioral health* therapeutic focus;

3. Group sessions centered on cognitive behavioral constructs, social/occupational/educational skills development and family interaction;

4. Additional emphasis on recovery strategies, monitoring of participation in 12-step programs and random drug screenings for the treatment of *substance abuse*; and

5. *Qualified practitioner* availability for medical and medication management.

Intensive outpatient program does not include services that are for:

1. *Custodial care*; or

2. Day care.

K

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

L

Late applicant means an *employee* and/or an *employee's* eligible *dependent* who applies for medical coverage more than 35 days after the eligibility date. An individual shall not be considered a late enrollee if: (a) the person enrolls during his/her initial enrollment period; (b) the person enrolls during any annual open enrollment period; or (c) the person enrolls during a *Special Enrollment period*.

M

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

Maximum allowable fee for a *covered expense* is the lesser of:

1. The fee charged by the *provider* for the *services*;

2. The fee that has been negotiated with the *provider* whether directly or through one or more intermediaries or shared savings contracts for the *services*;

3. The fee established by this *Plan* by comparing rates from one or more regional or national databases or schedules for the same or similar *services* from a geographical area determined by this *Plan*;

4. The fee based upon rates negotiated by this *Plan* or other payors with one or more *participating providers* in a geographic area determined by this *Plan* for the same or similar *services*;

5. The fee based upon the *provider's* cost for providing the same or similar *services* as reported by such *provider* in its most recent publicly available *Medicare* cost report submitted to the Centers for *Medicare* and Medicaid Services (CMS) annually; or

6. The fee based on a percentage determined by this *Plan* of the fee *Medicare* allows for the same or similar *services* provided in the same geographic area.

Note: The bill *you* receive for *services* from *non-participating providers* may be significantly higher than the *maximum allowable fee*. In addition to *deductibles*, *copayments* and *coinsurance*, *you* are responsible for the difference between the *maximum allowable fee* and the amount the *provider* bills *you* for the *services*. Any amount *you* pay to the *provider* in excess of the *maximum allowable fee* will not apply to *your out-of-pocket limit* or *deductible*.

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

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

1. Performed in the least costly setting required by *your* condition;

2. Not provided primarily for the convenience of the patient or the *qualified practitioner*;

3. Appropriate for and consistent with *your* symptoms or diagnosis of the *sickness* or *bodily injury* under treatment;

4. Furnished for an appropriate duration and frequency in accordance with accepted medical practices, and which are appropriate for *your* symptoms, diagnosis, *sickness* or *bodily injury*; and

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

Medicare means a program of medical insurance for the aged and disabled, as established under Title 18 of the Social Security Act of 1965, as amended.

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

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

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

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

Morbid obesity (clinically severe obesity) means a body mass index (BMI) as determined by a *qualified practitioner* as of the date of *service* of:

1. 40 kilograms or greater per meter squared (kg/m^2); or

2. 35 kilograms or greater per meter squared (kg/m^2) with an associated comorbid condition such as hypertension, type II diabetes, life-threatening cardiopulmonary conditions; or joint disease that is treatable, if not for the obesity.

N

Non-participating (Non-PAR) provider means a *hospital*, *qualified treatment facility*, *qualified practitioner* or any other health *services provider* who has not entered into an agreement with the *Plan Manager* (Humana) to provide *participating provider services* or has not been designated by the *Plan Manager* (Humana) as a *participating provider*.

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

O

Off-evidence drug indications means indications for which there is a lack of sufficient evidence for safety and/or efficacy for a particular medication.

Off-label drug indications means prescribing of an FDA-approved medication for a use or at a dose that is not included in the product indications or labeling. This term specifically refers to drugs or dosages used for diagnoses that are not approved by the FDA and may or may not have adequate medical evidence supporting safety and efficacy. Off-label prescribing of traditional drugs is a common clinical practice and many off-label uses are effective, well documented in peer reviewed literature and widely employed as standard of care treatments.

Orthotic means a custom-fitted or custom-made braces, splints, casts, supports and other devices used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body when prescribed by a *qualified practitioner*.

Out-of-pocket limit, if applicable, is a specified dollar amount that must be satisfied, either individually or combined as a covered family, per *calendar year* before a benefit percentage will be increased. Any *deductible* amount, where applicable, will be included in the out-of-pocket maximum. When the *out-of-pocket limit* is reached, *coinsurance* ceases for those *covered services* specified in the schedule of benefits. It does not include any amounts not paid because a *maximum benefit* limit has been reached, co-payments, or any amount above an *eligible expense*.

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

P

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

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

1. For a comprehensive and intensive interdisciplinary psychiatric treatment for minimum of 5 hours a day, 5 days per week;

2. That provides for social, psychological and rehabilitative training programs with a focus on reintegration back into the community and admits children and adolescents who must have a treatment program designed to meet the special needs of that age range; and

3. That has physicians and appropriately licensed *mental health* and *substance abuse* practitioners readily available for the emergent and *urgent care* needs of the patients.

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

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

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

Participating (PAR) provider means a *hospital*, *qualified treatment facility*, *qualified practitioner* or any other health *services provider* who has entered into an agreement with, or has been designated by, Humana to provide specified *services* to all *covered persons.*

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

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

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

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

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

Plan Administrator means Commonwealth of Kentucky.

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

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

Plan Sponsor means Commonwealth of Kentucky.

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

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

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

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

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

Pre-existing condition means a physical or mental condition for which *you* have received medical attention (medical attention includes, but is not limited to: *services* or care) during the 6 month period immediately prior to the *enrollment date* of *your* medical coverage under this *Plan*. *Pre-existing conditions* are covered after the end of a period of 12 months after the *enrollment date* (first day of coverage or, if there is a *waiting period*, the first day of the *waiting period*).

Pre-existing condition limitations will be waived or reduced for *pre-existing conditions* that were satisfied under previous *creditable coverage*. This *pre-existing condition* limitation does not apply to a *covered person* who is under the age of 19.

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

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

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

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

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

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

4. The name and address of the prescribing *qualified practitioner*.

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

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

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

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

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

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

Q

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

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

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

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

R

Registered Nurse First Assistant means a nurse who:

1. Holds a current active registered nurse licensure;

2. Is certified in perioperative nursing; and

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

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

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

Residential treatment facility means an institution which:

1. Is licensed as a 24-hour residential facility for *mental health* and *substance abuse* treatment, although not licensed as a *hospital*;

2. Provides a multidisciplinary treatment plan in a controlled environment, with periodic supervision of a physician or a Ph.D. psychologist; and

3. Provides programs such as social, psychological and rehabilitative training, age appropriate for the special needs of the age group of patients, with focus on reintegration back into the community.

Residential treatment is utilized to provide structure, support and reinforcement of the treatment required to reverse the course of behavioral deterioration.

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

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

S

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

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

Single coverage means coverage for the *member* only.

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

Sound natural tooth means a tooth that:

1. Is organic and formed by the natural development of the body (not manufactured);

2. Has not been extensively restored;

3. Has not become extensively decayed or involved in periodontal disease; and

4. Is not more susceptible to injury than a whole natural tooth.

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

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

Substance abuse means the abuse of, or psychological or physical dependence on, or addiction to alcohol or a controlled substance.

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

Summary Plan Description (SPD) means this document which outlines the benefits, provisions and limitations of this *Plan*.

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

T

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

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

1. Physical Therapy – The treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, biomechanical and neurophysiological principles and devices to relieve pain, restore maximum function, and prevent disability following disease, *bodily injury* or loss of a body part.

2. Respiratory Therapy – Introduction of dry or moist gases into the lungs for treatment purposes.

3. Speech Therapy – The treatment rendered to gain speech loss due to *sickness* or *bodily injury*, or as a result of complications at birth, congenital anomaly, or previous medical treatment.

4. Cardiac Rehabilitation – Treatment provided to individuals who have suffered a heart attack, have had heart *surgery*, or have other cardiac problems.

5. Occupational Therapy – The treatment program of prescribed activities coordination and mastery, designed to assist a person to gain independence, particularly in the normal activities of daily living.

Timely applicant means an *employee* and/or an *employee's* eligible *dependent* who applies for medical coverage within 35 days of the eligibility date.

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

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

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

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

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

TRICARE is the name of the federal government's managed health care program for active-duty military, active-duty service families, retirees and their families, and other beneficiaries. An individual who is ordered to active duty for more than 30 days is automatically enrolled in *TRICARE* (*TRICARE* Prime a HMO-type option) and the individual's dependents are also eligible to receive benefits under *TRICARE*.

U

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

1. Could seriously jeopardize the life or health of the *claimant* or the ability of the *claimant* to regain maximum function; or

2. In the opinion of a physician with knowledge of the *claimant's* medical condition, would subject the *claimant* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *claim*; or

3. Generally, whether a *claim* is a *claim* involving *urgent care* will be determined by the *Plan Manager* (Humana). However, any *claim* that a physician with knowledge of a *claimant's* medical condition determines is a "*claim* involving *urgent care*" will be treated as a "*claim* involving *urgent care*."

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

W

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

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

Y

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

SECTION 7

ADDITIONAL NOTICES

NOTICE TO ENROLLEES CONCERNING TOBACCO

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

THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices (the "Notice") describes the legal obligations of Commonwealth of Kentucky, **Personnel Cabinet, Department of Employee Insurance's Kentucky Employees' Health Plan (KEHP)** (the "Plan") and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice of Privacy Practices to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, that relates to: (1) your past, present or future physical or mental health or condition; (2) the provision of health care to you; or (3) the past, present or future payment for the provision of health care to you.

If you have any questions about this Notice or about our privacy practices, please contact:
Joe R. Cowles, Deputy Executive Director, Office of Legal Services, Personnel Cabinet, 501 High Street, 3rd Floor, Frankfort, Kentucky 40601, (502) 564-7430.

Effective Date: This Notice is effective January 1, 2012.

Our Responsibilities: We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices by U.S. mail to your last-known address on file.

How We May Use and Disclose Your Protected Health Information: Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Payment. We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or
subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations. We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities.

To Business Associates. We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a
Business Associate contract with us.

As Required by Law. We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety. We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors. For the purpose of administering the plan, we may disclose to certain employees protected health information. However, those employees will only use or disclose that information as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations: In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation. If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose your protected health information for public health actions. These actions generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that an adult patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities. We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may disclose your protected health information if asked to do so by a law enforcement official—

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct; and
- about criminal conduct.

Coroners, Medical Examiners and Funeral Directors. We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors, as necessary to carry out their duties.

National Security and Intelligence Activities. We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research. We may disclose your protected health information to researchers when:
(1) the individual identifiers have been removed; or
(2) when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures: The following is a description of disclosures of your protected health information we are required to make.

Government Audits. We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You. When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Other Disclosures:

Personal Representatives. We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that: (1) you have been, or may be, subjected to domestic violence, abuse or neglect by such person; or (2) treating such person as your personal representative could endanger you; and (3) in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members. With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations. Other uses or disclosures of your protected health information not described above will only be made with your written authorization. You may revoke written authorization at any time, so long as the revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Your Rights: You have the following rights with respect to your protected health information:

Right to Inspect and Copy. You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, you must submit your request in writing to Commonwealth of Kentucky, Personnel Cabinet, Department of Employee Insurance, ATTN: HIPAA, 501 High Street, 2nd Floor, Frankfort, KY 40601.

If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request to Commonwealth of Kentucky, Personnel Cabinet, Department of Employee Insurance, ATTN: HIPAA, 501 High Street, 2nd Floor, Frankfort, KY 40601.

Right to Amend. If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, your request must be made in writing and submitted to Commonwealth of Kentucky, Personnel Cabinet, Department of Employee Insurance, ATTN: HIPAA, 501 High Street, 2nd Floor, Frankfort, KY 40601. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures. You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to Commonwealth of Kentucky, Personnel Cabinet, Department of Employee Insurance, ATTN: HIPAA, 501 High Street, 2nd Floor, Frankfort, KY 40601.

Your request must state a time period of not longer than six years and may not include dates before April 14, 2003.

Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had. Except as provided in the next paragraph, we are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you.

Effective February 17, 2010 (or such other date specified as the effective date under applicable law), we will comply with any restriction request if: (1) except as otherwise required by law, the disclosure is to the health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out-of-pocket in full.

To request restrictions, you must make your request in writing to Commonwealth of Kentucky, Personnel Cabinet, Department of Employee Insurance, ATTN: HIPAA, 501 High Street, 2nd Floor, Frankfort, KY 40601. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limitations to apply— for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to Commonwealth of Kentucky, Personnel Cabinet, Department of Employee Insurance, ATTN: HIPAA, 501 High Street, 2nd Floor, Frankfort, KY 40601. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

Right to be Notified of a Breach. You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured protected health information.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our website, http://personnel.ky.gov/dei/hipaa.htm.

To obtain a paper copy of this notice, you may make that request to: Commonwealth of Kentucky, Personnel Cabinet, Department of Employee Insurance, ATTN: HIPAA, 501 High Street, 2nd Floor, Frankfort, KY 40601.

Complaints: If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact Commonwealth of Kentucky, Personnel Cabinet, Department of Employee Insurance, 501 High Street, 2nd Floor, Frankfort, KY 40601. All complaints must be submitted in writing.

You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with us.

Dependent Eligibility Rules and Verification Requirements for Plan Year 2012

Eligibility Definition	Documentation Required
Spouse A person of the opposite sex to whom *you* are legally married.	A legible photocopy of the Marriage Certificate OR a legible photocopy of the top half of the front page of the *employee*/retiree's most recent federal tax return (Form 1040)
Common Law Spouse A person of the opposite sex with whom *you* have established a Common Law union in a state which recognizes Common Law marriage (Kentucky does not recognize Common Law Marriage).	A legible photocopy of the Certificate or Affidavit of Common Law Marriage from a state that recognizes Common Law Marriage.
Child Age 0 to 18 **In the case of a child who has not yet attained his/her 19th birthday**, "child" means an individual who is – • A son, daughter, stepson, or stepdaughter of the *employee*/retiree, or • An eligible foster child of the *employee*/retiree (eligible foster child means an individual who is placed with the *employee*/retiree by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction), or • An adopted child of the *employee*/retiree (a legally adopted individual of the *employee*/retiree, or an individual who is lawfully placed with the *employee*/retiree for legal adoption by the *employee*/retiree, shall be treated as a child), or • A grandchild for whom the *employee*/retiree has been awarded guardianship or custody by a court of competent jurisdiction.	**Natural Child**: A legible photocopy of the child's birth certificate showing the name of the *employee*/retiree as a parent. **Step Child**: A legible photocopy of the child's birth certificate showing the name of the *employee/*retiree's spouse as a parent; **and** a legible copy of the marriage certificate showing the names of the *employee*/retiree and the spouse. **Legal Guardian, Adoption, Grandchild(ren) or Foster Child(ren)**: Legible photocopies of Court Orders, Guardianship Documents, Affidavits of Dependency, with the presiding judge's signature and filed status; **or** legible Adoption or Legal Placement Decrees with the presiding judge's signature.

Child Age 19 to 25 **In the case of a child who has attained his/her 19th birthday but who has not yet attained his/her 26th birthday**, "child" means an individual who is – • A son, daughter, stepson, stepdaughter, eligible foster child, an adopted child or a grandchild of the *employee*/retiree – as described above; **AND** • Is NOT eligible to enroll in an *employer*-sponsored health plan offered by the child's *full-time employer*.	Must submit the documents described above for children **and** the **Kentucky *Employees*' Health Plan 2011 Certification of Dependent Eligibility** form.
Disabled Dependent A *dependent* child who is totally and permanently disabled may be covered on *your* KEHP benefit plan beyond the end of the month in which he/she turns 26, provided the disability (a) started before his/her 26th birthday and (b) is medically-certified by a physician. A disabled child who was not covered on this Plan prior to his/her 26th birthday may not be enrolled in KEHP unless he/she sustains a specific qualifying event.	Contact the Enrollment Information Branch at 502-564-1205 for the specific documentation needed.
Cross Reference Payment Option A payment option involving two *employees*/retirees who are a legally married couple and enroll themselves and at least one child as a *dependent* in a KEHP family plan.	Documentation listed above to verify spouse and children.

Grievance Process for Eligibility and Enrollment Issues

An *employee* who is dissatisfied with a decision regarding enrollment or disenrollment (Qualifying Events) in the Plan, may file a grievance to the **Department of Employee Insurance** 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 of Employee Insurance
Attention: Grievance Committee
501 High Street, Second Floor
Frankfort, KY 40601

A grievance must include ALL of the following items:

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

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

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

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

NOTE: This Grievance Committee does not review medical claims. A grievance for a medical claim must be filed with Humana.

Administered by:

HUMANA.
Guidance when you need it most

Humana Insurance Company
500 West Main Street
Louisville, KY 40202

Copyright 2012