



**KENTUCKY EMPLOYEES'
HEALTH PLAN**

SUMMARY PLAN DESCRIPTION

**COMMONWEALTH
MAXIMUM CHOICE**

PRESCRIPTION DRUG PLAN

Sponsored by the
Commonwealth of Kentucky

EFFECTIVE JANUARY 1, 2011

TABLE OF CONTENTS

Plan Description Information	1
Grandfather Clause	3
Schedule of Benefits	4
Prescription Drug Cost Sharing	4
Formulary	4
Prescription Drug Coverage	5
Ancillary Fee	5
Smoking Cessation	5
CuraScript Pharmacy	5
Step Therapy	6
Prior Authorization	8
Quantity Level Limits	10
Retail Pharmacy	11
Maintenance Drug Benefit—Mail Order And Retail Pharmacy	11
Non-Participating Pharmacy	12
Inherited Metabolic Diseases	12
Prescription Drug Exclusions	13
Eligibility and Effective Date of Coverage	15
Claim Information	16
Coordination of Benefits	17
Reimbursement/Subrogation	19
General Provisions	23
Claims Procedures	26
Appeals	30
Legal Notices	34
Definitions	43

PLAN DESCRIPTION INFORMATION

1. Proper Name of Plan: Kentucky Employees' Health Plan
Common Name of Plan: Commonwealth of Kentucky
2. Plan Sponsor and *Employer*:
Commonwealth of Kentucky
Personnel Cabinet, Department of Employee Insurance
501 High Street, Second Floor
Frankfort, KY 40601
(502) 564-0358
3. Plan Administrator -
Commonwealth of Kentucky
Personnel Cabinet, Department of Employee Insurance
501 High Street, Second Floor
Frankfort, KY 40601
(502) 564-0358
4. *Employer* Identification Number: 61-0600439
5. The Plan provides *prescription* drug benefits for participating *employees* and their enrolled *dependents*.
6. Plan benefits described in this booklet are effective January 1, 2011
7. The *Plan year* is January 1 through December 31 of each year.
8. Service of legal process may be served upon the Plan Administrator as shown above or the following agent for service of legal process:
Commonwealth of Kentucky
Personnel Cabinet, Office of Legal Services
501 High Street, Third Floor
Frankfort, KY 40601
(502) 564-7430
9. The *Plan Manager* is responsible for performing certain delegated administrative duties, including the processing of claims. The *Plan Manager* is:
Express Scripts, Inc.
13900 Riverport Drive
Maryland Heights, MO 63043
Telephone: 877-597-7474

PLAN DESCRIPTION INFORMATION (continued)

10. This is a self-insured *prescription* benefit plan. The cost of the Plan is paid with contributions shared by the *employer* and *employee*. Benefits under the Plan are provided from the general assets of the *employer* and are used to fund payment of covered claims under the Plan plus administrative expenses.
11. Each *employee* of the *employer* who participates in the Plan has access to a Summary Plan Description (SPD), which is this booklet. This booklet will be available through the Personnel Cabinet's web site at www.kehp.ky.gov. It contains information regarding the benefits provided and other Plan information.
12. The Plan benefits and/or contributions may be modified or amended from time to time, or may be terminated at any time by the Plan Sponsor. Significant changes to the Plan, including termination, will be communicated to participants as required by applicable law.
13. Upon termination of the Plan, the rights of the participants to benefits are limited to claims incurred and payable by the Plan up to the date of termination. Plan assets, if any, will be allocated and disposed of for the exclusive benefit of the participating *employees* and their *dependents* covered by the Plan, except that any taxes and administration expenses may be made from the Plan assets.
14. The Plan does not constitute a contract between the *employer* and any *covered person* and will not be considered as an inducement or condition of the employment of any *employee*. Nothing in the Plan will give any *employee* the right to be retained in the service of the *employer*, or for the *employer* to discharge any *employee* at any time.
15. This Plan is not in lieu of and does not affect any requirement for coverage by Workers' Compensation insurance.
16. This Plan is included in the Commonwealth of Kentucky Flexible Benefits Plan, a cafeteria plan created pursuant to the Internal Revenue Code, Subsection 125.
17. This Plan only reflects your *prescription* benefit plan. This Summary Plan Description should be read in conjunction with your applicable *medical* plan Summary Plan Description.

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.

SCHEDULE OF BENEFITS		
	In-network	Out-of-network
Tier 1 – <i>Generic</i>	10% after Deductible*	40% after Deductible*
Tier 2 – Formulary Brand	10% after Deductible*	40% after Deductible*
Tier 3 – Non-Formulary Brand	10% after Deductible*	40% after Deductible *
<i>Prescription Drug Maximum Supply is 30 days</i>		

Maintenance Drug Benefit from Mail Order and Retail Pharmacy (see page 12 for more details)		
	In-Network	Out-of-Network
Tier 1 – <i>Generic</i>	10% after Deductible*	Not Covered
Tier 2 – Formulary Brand	10% after Deductible*	Not Covered
Tier 3 – Non-Formulary Brand	10% after Deductible*	Not Covered
<i>Mail Order Maintenance and Retail Maintenance Prescription Drug Maximum is 90 days</i>		

*For details on the deductible and out-of-pocket maximums, refer to the Commonwealth Maximum Choice Plan’s *medical* Summary Plan Description, which is available on the web at <http://kehp.ky.gov>.

PRESCRIPTION DRUG COST SHARING

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

You are responsible for payment of:

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

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

FORMULARY

The *Kentucky Employees’ Health Plan* utilizes Express Scripts’ 2011 National Preferred Formulary. This formulary is subject to change throughout the year. You may request a copy by calling 877-597-7474 or by visiting Express Scripts’ web site at www.express-scripts.com.

PREScription DRUG COVERAGE

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

Covered *prescription* drugs, medicine or medications must:

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

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

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

ANCILLARY FEE

If you purchase a Tier 2 or a Tier 3 *prescription*, and there is a therapeutically equivalent Tier 1 *prescription* available, then you must pay the applicable copay as listed above **plus** the difference between the cost of the Tier 2 or Tier 3 *prescription* and the cost of the Tier 1 *prescription*. This is referred to as an ancillary fee. If the physician writes on the *prescription* “dispense as written”, there will not be any ancillary fees charged.

SMOKING CESSATION

The *Kentucky Employees' Health Plan* provides a benefit for certain *over-the-counter* (OTC) nicotine replacement therapies. This program requires active participation in an approved tobacco cessation program. Participants in this program will receive a benefit for these therapies at an appropriate *co-payment*. You will find more information on the smoking cessation program at 1-877-KEHPWELL or www.kehpwellonline.com.

CURAScript PHARMACY—SPECIALTY DRUGS

The *Kentucky Employees' Health Plan* uses the *CuraScript Pharmacy* for specialty injectable drugs used to treat chronic conditions. The *CuraScript Pharmacy*, a wholly owned subsidiary of Express Scripts, is a national provider of specialty *pharmacy* services offering a broad range of healthcare products and services for individuals with chronic health conditions such as growth hormone deficiencies, hepatitis C, hemophilia, HIV/AIDS, cancer, multiple sclerosis, rheumatoid arthritis, and many others. *CuraScript Pharmacy* provides comprehensive patient management services including clinical case management programs, counseling, education, and social services. Medications will be ordered specifically for you and delivered to your home.

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

CuraScript Pharmacy has a complete specialty *pharmacy* inventory with many specialty medications that are not readily available at a local *pharmacy*.

- delivers your specialty medications directly to you or your doctor.
- provides you with the necessary supplies you need to administer your medications — at no additional cost.
- offers clinically based care management programs — which include consultation with your doctor — to help you get the most benefit from the specialty medications that your doctor has prescribed for you.

CuraScript Pharmacy will allow you to receive your first *prescription* from any *participating pharmacy*. However, after the initial *prescription* is filled, all remaining *prescriptions* must be filled by *CuraScript Pharmacy*. *CuraScript Pharmacy* will manage all of your *prescriptions* and a Patient Care Coordinator will work with you to ensure you receive the care you need. Your specialty drugs will be delivered to your home within a reasonable time, usually within 24 hours. Included with your specialty drugs will be all your needed supplies – needles, syringes, alcohol swabs and sharps containers, at no additional cost to you.

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

STEP THERAPY

The Step Therapy program is especially for people who take *prescription* drugs regularly for an ongoing condition, such as arthritis, asthma, or high blood pressure.

The Step Therapy program moves you along a well-planned path with your doctor approving your medications. Your path starts with “first-step” drugs — usually Tier 1, *generic* drugs proven to be safe and effective. You will pay the lowest *co-payment/co-insurance* for Tier 1 *prescriptions*. If the ‘first-step’ drug is not effective, you may be approved to try a “second-step” Tier 2 or other brand-name drug, if medically necessary.

In some situations, if specific medical criteria have been met, a member may be granted *prior authorization* for a Tier 2, second-step prescription drug without the trial of a Tier 1, first-line *prescription* drug.

Break in Therapy

If you have been taking a drug that requires Step Therapy, and for any reason, the *prescription* drug is not refilled within 130 days from the last fill, you will be required to begin Step Therapy again. This is considered a “break in therapy”, and you must begin Step Therapy again, unless your doctor receives a *prior authorization* and approval.

Examples of prescription drugs requiring Step Therapy:

Step Therapy Program	Medication
ADD/ADHD	Strattera
Allergies	Clarinet, Xyzal, Allegra-D, Nasonex, Rhinocort Aqua, Nasacort AQ, Beconase AQ, Veramyst
Antidepressants	Celexa, Effexor XR, Lexapro, Prozac, Sarafem, Paxil, Paxil CR, Zoloft
Anti-inflammatory	Arthrotec, Mobic, Ponstel, Celebrex
Asthma, COPD	Singulair, Accolate, Xopenex
Diabetes	Actos, Avandia, Avandaryl, Avandamet, Duetact, Januvia, Janumet, Glucophage XR, Glumetza, Fortamet, Riomet
Enlarged Prostate	Avodart, Proscar
High Blood Pressure	Lotrel, Altace, Lotensin, Avapro, Cozaar, Aceon, Vasotec, Benicar, Norvasc, Cardene SR, Sular, DynaCirc CR, Covera-HS, Veralan PM, Procardia XL, Plendil, Coreg, Toprol XL
High Cholesterol	Caduet, Lescol, Lescol XL, Pravachol, Advicor, Altoprev, Crestor, Vytorin, Welchol, Zetia, Tricor, Trilipix
Osteoporosis	Fosamax, Actonel, Boniva
Over-Active Bladder	Detrol, Ditropan, Sanctura, Vesicare, Enablex, Oxytrol, Gelnique, Toviaz
Stomach Acid	Nexium, Prevacid, Protonix

NOTE: This listing is not a comprehensive listing and it is subject to change throughout the year.

PRIOR AUTHORIZATION

There are some *prescription* drugs that require an authorization from Express Scripts before you will be able to receive them—this is called *prior authorization*. Express Scripts will ensure the *prescriptions* meet certain conditions for coverage. If *prior authorization* is received, the *prescription* will be covered under the corresponding *co-payment* level. The *prior authorization* typically will remain in effect for one year from the date the original *prior authorization* is received. Once the *prior authorization* period is exhausted, your physician must contact Express Scripts to request another *prior authorization*. If *prior authorization* is not received, the *prescription* will not be covered.

Prior Authorization Hotline

The most efficient way to initiate a *prior authorization* review is to ask your physician to contact Express Scripts' *prior authorization* hotline at 800-241-1390. If the request is approved, an override code is provided for the *pharmacist*. If the request is not approved, a follow-up letter will be mailed to you and your physician.

Prior Authorization Form

Your physician may also fax a *prior authorization* form to Express Scripts. *Prior authorization* forms may be obtained from Express Scripts at 877-KY-SPIRIT (877-597-7474). *Prior authorization* forms may only be completed by your physician or *pharmacist*.

The following page includes a listing of the most commonly prescribed drugs requiring a *prior authorization*. This is not a complete list. To verify if a *prescription* drug requires *prior authorization*, call 877-597-7474 or visit the *Plan Manager's* web site at www.express-scripts.com.

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

- Actemra
- Adcirca
- Adipex**
- Amevive
- Aralast NP
- Aranesp
- Atralin gel
- Avita
- Avonex
- Betaseron
- Bontril**
- Botox
- Buproban*
- Carimune NF Nanofiltered
- Chantix*
- Cimzia
- Copaxone
- Didrex**
- Diethylpropion**
- Dysport
- Eligard
- Enbrel
- Epogen
- Euflexxa
- Extavia
- Fastin**
- Flebogamma
- Flolan
- Forteo
- Gammagard Liquid
- Gammagard S/D
- Gamunex
- Genotropin
- Humatrope
- Humira
- Hyalgan
- Increlex
- Ionamin**
- Iplex
- Kineret
- Letairis
- Lidoderm patch
- Lupron
- Melfiat**
- Myobloc
- Neulasta
- Neupogen
- Nicotrol*
- Norditropin
- Nutropin
- Nutropin AQ
- Nuvigil
- Octagam
- Omnitrope
- Orenzia
- Orthovisc
- Pegasys
- Peg-Intron
- Phendimetrazine**
- Phentermine**
- Prelu-2**
- Privigen Liquid
- Procrit
- Pro-Fast**
- Prolastin
- Provigil
- Raptiva
- Rebif
- Regranex
- Remicade
- Remodulin
- Retin-A
- Retin-A Micro
- Revatio
- Rituxan
- Saizen
- Serostim
- Simponi
- Stelara
- Supartz
- Synagis
- Synvisc
- Synvisc-One
- Tazorac
- Tenuate**
- Tev-Tropin
- Topamax
- Tracleer
- Tretin X
- Tretinoin (topical products)
- Tysabri
- Tyvaso
- Ventavis
- Vfend
- Vivaglobin
- Xenical**
- Xolair
- Zemaira
- Ziana
- Zonegran
- Zorbtive
- Zyban*

NOTE: This listing is not a comprehensive listing and it is subject to change throughout the year.

* **The Kentucky Employees' Health Plan will cover the cost of certain smoking cessation drugs that require a written *prescription*. Your doctor must call for *prior authorization*. The co-pay will be the applicable copay for a 30-day supply, limited to a maximum of three (3) fills per calendar year. Smoking cessation drugs are not eligible for the maintenance mail order or the maintenance at retail drug program.**

** **The Kentucky Employees' Health Plan will cover these *prescription* drugs if you are enrolled in the Why Weight Kentucky program with Humana. Why Weight Kentucky is a weight management program that is designed to assist you in achieving and maintaining a healthy weight. To qualify for the Why Weight Kentucky program, you must have a Body Mass Index (BMI) of greater than thirty (30). For additional information regarding the Why Weight Kentucky program, call 1-877-KEHPWELL or visit www.kehpwellonline.com.**

QUANTITY LEVEL LIMITS (QLL)

Some *prescriptions* are subject to *Quantity Level Limits (QLL)*. A QLL is placed on a *prescription* drug that should be limited in quantity, day supply and/or number of months. *QLLs* ensure *that* you receive the medication you need in the quantity that is considered safe and recommended by the drug manufacturer, the U.S. Food & Drug Administration (FDA) and clinical studies.

At the *pharmacy*, you may be advised that your *prescription* is written for a larger quantity than your Plan allows. If so, you can fill the *prescription* for the quantity that is within the QLL. Any amount above the QLL, will not be covered by the Plan. If your physician doesn't agree with the QLL he or she should contact Express Scripts to request a *prior authorization*, which may allow you to receive a greater quantity.

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

RETAIL PHARMACY

Your Plan provisions include a retail *prescription* drug benefit. Your health insurance identification (ID) card will provide the information for you to present to your *pharmacy*. Present your ID card at a *participating pharmacy* when purchasing a *prescription*. *Prescriptions* dispensed at a retail *pharmacy* are limited to a thirty (30) day supply per *prescription* or refill, except as provided under the Maintenance Drug Benefit below.

MAINTENANCE DRUG BENEFIT—MAIL ORDER AND RETAIL PHARMACY

Your *prescription* drug benefits include a maintenance drug benefit. If you are being prescribed a maintenance drug, as classified by the Plan, you can save money by receiving your maintenance drug *prescription* through the Express Scripts mail order *pharmacy* or through a participating retail *pharmacy*. You save money either way! Only prescription drugs classified as maintenance drugs by the Plan will be eligible for maintenance drug benefits.

Mail Order through Express Scripts Pharmacy

If you have your *prescription* filled by the Express Scripts mail order *pharmacy*, your *prescriptions* will be shipped to your home address saving you time and money. The mail order benefit will save you money by providing you a ninety (90) day supply of your maintenance drug at a reduced amount. Refer to the Schedule of Benefits for details.

Retail Pharmacy

If you have your maintenance *prescription* filled by a participating retail *pharmacy*, you will receive a ninety (90) day supply at a reduced amount. Participating pharmacies must meet the terms and conditions for participation established by Express Scripts, including price and dispensing fee.

Maintenance Drug Benefits will only be filled with the quantity prescribed by your physician and are limited to a maximum of a:

- 90-day supply per *prescription* or refill from Express Scripts' mail order *pharmacy*; or a
- 90-day supply per *prescription* or refill for *self-administered injectable medications*; or a
- 90-day supply per *prescription* or refill from a *participating pharmacy*.

Maintenance Drug Benefits shall not permit the dispensing of a controlled substance classified in Schedule II-V – either through Express Scripts mail order or the retail *pharmacy*.

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

NON-PARTICIPATING PHARMACY

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

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

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

Mail *pharmacy* receipts to:

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

INHERITED METABOLIC DISEASES

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

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

Coverage under this benefit is subject to a *plan year* benefit maximum of \$25,000 for medical formulas and a separate *plan year* benefit maximum of \$4,000 for low protein modified foods. Benefits are payable at the Tier 3 *co-payment*.

PRESCRIPTION DRUG EXCLUSIONS

Expenses incurred will not be payable for the following:

1. Any drug, medicine, medication or supply not approved for coverage under the Plan;
2. *Legend drugs* which are not recommended and not deemed necessary by a *physician*;
3. More than two fills for the same drug or therapeutic equivalent medication prescribed by one or more *physicians* and dispensed by one or more retail *pharmacies*;
4. Charges for the administration or injection of any drug;
5. Drug delivery implants;
6. Any drug, medicine or medication labeled “Caution-Limited by Federal Law to Investigational Use,” or experimental drug, medicine or medication, even though a charge is made to you;
7. Any drug, medicine or medication that is consumed or injected at the place where the *prescription* is given, or dispensed by the *physician*;
8. *Prescriptions* that are to be taken by or administered to the *covered person*, in whole or in part, while he or she is a patient in a facility where drugs are ordinarily provided by the facility on an inpatient basis. Inpatient facilities include, but are not limited to:
 - a. Hospital;
 - b. Skilled nursing facility; or
 - c. Hospice facility;
9. Any drug prescribed for intended use other than for:
 - a. Indications approved by the FDA; or
 - b. Recognized off-label indications through peer-reviewed medical literature;
10. *Prescription* refills:
 - a. In excess of the number specified by the *physician*; or
 - b. Dispensed more than one year from the date of the original order;
11. Any drug for which a charge is customarily not made;
12. Therapeutic devices or appliances, including: hypodermic needles and syringes (except needles and syringes for use with insulin, and covered *self-administered injectable drugs*); support garments; test reagents; mechanical pumps for delivery of medication; and other non-medical substances, unless otherwise specified by the Plan;
13. Dietary supplements, nutritional products, fluoride supplements and products, minerals, herbs and vitamins (except pre-natal vitamins, including greater than one milligram of folic acid, and pediatric multi-vitamins with fluoride), unless otherwise specified by the Plan;
14. Injectable drugs, including but not limited to: immunizing agents; biological sera; blood; blood plasma; or *self-administered injectable drugs* not covered under the Plan;
15. Any drug prescribed for an *illness* or *bodily injury* not covered under this Plan;
16. Any portion of a *prescription* or refill that exceeds a thirty (30) day supply (or a ninety (90) day supply for a *prescription* or refill received from the Maintenance Drug Benefit.);
17. Any portion of a *prescription* refill that exceeds the drug specific *dispensing limit*, is dispensed to a *covered person* whose age is outside the drug specific age limits, or exceeds the duration-specific *dispensing limit*, if applicable;
18. Any drug, medicine or medication received by the *covered person*:
 - a. Before becoming covered under the Plan; or
 - b. After the date the *covered person's* coverage under the Plan has ended;
19. Any costs related to the mailing, sending, or delivery of *prescription* drugs;
20. Any fraudulent misuse of this benefit including *prescriptions* purchased for consumption by someone other than the *covered person*;
21. *Prescription* or refill for drugs, medicines, or medications that are spilled, spoiled, or damaged;
22. Any drug or medicine that is:
 - a. Lawfully obtainable without a *prescription* (*over-the-counter* drugs), except insulin; or

- b. Available in *prescription* strength without a *prescription (over-the-counter equivalent)*;
- 23. Any drug or biological that has received an “*orphan drug*” designation, unless approved by the Plan Administrator;
- 24. Any amount you paid for a *prescription* that has been filled, regardless of whether the *prescription* is revoked or changed due to adverse reaction or change in dosage or *prescription*;
- 25. More than one *prescription* within a 23-day period for the same drug or therapeutic equivalent medication prescribed by one or more *physicians* and dispensed by one or more *pharmacies*, unless received from a mail order *pharmacy*. For drugs received from a mail order *pharmacy*, more than one *prescription* within a 20-day period for a 1-30 day supply; or a 60-day period for a 61-90 day supply. (Based on the dosage schedule prescribed by the *physician*).
- 26. Homeopathic products
- 27. Depigmentation products
- 28. Topical and injectable cosmetic products
- 29. Hair growth or hair removal products
- 30. Diaphragms
- 31. Intra-uterine devices
- 32. Emergency contraceptives
- 33. Allergens
- 34. Durable medical equipment
- 35. Drugs that are not approved by the FDA

For some *prescription* drug exclusions, this Plan has an Exceptions Policy that may allow you to obtain a non-covered medication. For those exclusions, if criteria are met, you can receive a non-covered drug. For more information, please call 877-597-7474.

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

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

CLAIM INFORMATION

NOTICE OF CLAIM

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

PROOF OF LOSS

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

HOW TO FILE A PRESCRIPTION DRUG CLAIM

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

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

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

PAYMENT OF CLAIMS

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

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

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

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

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

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

COORDINATION OF BENEFITS

BENEFITS SUBJECT TO THIS PROVISION

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

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

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

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

EFFECT ON BENEFITS

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

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

ORDER OF BENEFIT DETERMINATION

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

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

If a plan other than this Plan does not include provision 3, then the gender rule (male's coverage 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*

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

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.

REIMBURSEMENT/SUBROGATION

RIGHT OF RECOVERY

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

SUBROGATION

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

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

1. The Plan has the right to recover payments for benefits paid for by the Plan.
2. The Plan has the right to recover payment for benefits paid by the Plan to or on behalf of you or your *dependent* from any award, settlement, or damages that you or your *dependent* may become entitled to or receive as a result of an accident, a person's fault or negligence, or any other circumstance under which you or your *dependent* has the right to recover from any other party.
3. The Plan may recover its benefit payments for any type of benefit which may be paid by the Plan, such as medical, dental, vision, mental, disability, supplemental accident, or accidental death or dismemberment benefits.
4. An "award, settlement, or damages" includes any award, settlement, damages (whether equitable, legal, compensatory, etc.), compensation, benefits, or any other payment of any kind. The amount may be paid by formal court award, informal compromise, redemption agreement, application for benefits, or otherwise. The amount also may be paid in a lump sum, installment, or annuity payments (such as income replacement). The Plan has the right to recover from all of these amounts.
5. An "award, settlement, or damages" includes amounts of any type, kind, nature, or character, regardless of whether the amount identifies or covers the Plan's benefit payments, otherwise relates to medical benefits, or is specifically limited to certain kinds of damages or payments. In addition, attorneys' fees or any other costs associated with the amount will not reduce the amount of the Plan's reimbursement. This Plan has the first priority to recover from your award, settlement, or damages. The Plan's first priority lien also will apply regardless of whether you or your *dependent* is or was made whole from the award, settlement, or damages, whether before or after the Plan's subrogation recovery. This Plan precludes the operation of the "make-whole" and "common fund" doctrines.

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

PLAN’S RIGHT TO ASSERT CLAIMS ON YOUR BEHALF

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

MISCELLANEOUS SUBROGATION

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

DUTY TO COOPERATE

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

RETENTION OF AN ATTORNEY

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

PARTICIPANT'S NONCOMPLIANCE

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

RIGHT TO COLLECT NEEDED INFORMATION

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

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

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

REIMBURSEMENT/SUBROGATION EXCLUSIONS

1. *Sickness* or *bodily injury* for which medical payments/personal injury protection (PIP) coverage exists under any automobile, homeowner, marine, aviation, premise, or any other similar coverage, whether such coverage is in effect on a primary, secondary, or excess basis. This exclusion applies up to the available limit under the other coverage regardless of whether a *claim* is filed with the medical payments/PIP *carrier*. Whether medical payment or expense coverage is payable under another coverage is to be determined as if the coverages under this Plan did not exist;
2. Any *covered expenses* to the extent of any amount received from others for the *bodily injuries* or losses which necessitate such benefits. "Amounts received from others" specifically includes, without limitation, liability insurance, workers' compensation, uninsured motorists, underinsured motorists, "no-fault" and automobile med-pay payments.

GENERAL PROVISIONS

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

CONTESTABILITY

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

RIGHT TO REQUEST OVERPAYMENTS

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

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

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

WORKERS' COMPENSATION NOT AFFECTED

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

WORKERS' COMPENSATION

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

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

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

MEDICAID

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

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

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

RIGHT OF RECOVERY

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

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

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

CONSTRUCTION OF PLAN TERMS

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

PRIVACY OF PROTECTED HEALTH INFORMATION

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

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

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

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

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

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

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

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

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

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

CLAIMS PROCEDURES

SUBMITTING A CLAIM

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

- Claims must be submitted to the *Plan Manager* at the address indicated in the documents describing the Plan or claimant's identification card. Claims will not be deemed submitted for purposes of these procedures unless and until received at the correct address.
- Claims submissions must be in a format acceptable to the *Plan Manager* and compliant with any applicable legal requirements. Claims that are not submitted in accordance with the requirements of applicable federal law respecting privacy of protected health information and/or electronic claims standards will not be accepted by the Plan.
- Claims submissions must be timely. Claims must be filed as soon as reasonably possible after they are incurred, and in no event later than **180 days** after the date of loss, except if you were legally incapacitated. Plan benefits are only available for claims that are incurred by a *covered person* during the period that he or she is covered under the Plan.
- Claims submissions must be complete. They must contain, at a minimum:
 - a. The name of the *covered person* who incurred the *covered expense*;
 - b. The name and address of the health care provider;
 - c. The diagnosis of the condition;
 - d. The procedure or nature of the treatment;
 - e. The date of and place where the procedure or treatment has been or will be provided;
 - f. The amount billed and the amount of the *covered expense* not paid through coverage other than Plan coverage, as appropriate;
 - g. Evidence that substantiates the nature, amount, and timeliness of each *covered expense* in a format that is acceptable according to industry standards and in compliance with applicable law.

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

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

Pharmacy claims and correspondence should be mailed to:

Express Scripts
P. O. Box 66773
St. Louis, MO 63166 – 6773
Attn: Claims Department

PROCEDURAL DEFECTS

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

ASSIGNMENTS AND REPRESENTATIVES

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

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

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

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

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

CLAIMS DECISIONS

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

PRE-SERVICE CLAIMS

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

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

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

URGENT CARE CLAIMS

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

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

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

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

CONCURRENT CARE DECISIONS

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

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

POST-SERVICE CLAIMS

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

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

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

TIMES FOR DECISIONS

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

PAYMENT OF CLAIMS

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

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

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

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

benefit payment, unless it receives written notice of valid claim before payment is made. The affidavit will release the Plan from further liability.

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

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

APPEALS

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

1. **Adverse Determination** means when the Plan determines that procedures performed or proposed to be performed are not medically necessary or are considered experimental or investigational and therefore are denied, reduced or terminated. An Adverse Determination does not mean a determination that the healthcare services are not covered. Express Scripts is responsible for the Internal Appeal Process for Adverse Determinations in accordance with KRS 304.17A.600-633.
2. **Coverage Denial** means services, treatments, drugs or devices that are specifically limited or excluded under the *covered person's* plan. Express Scripts is responsible for the Internal Appeal Process for Coverage Denials in accordance with KRS 304.17A.600-633.
3. **Administrative Appeals** are for situations that do not fall in the category of either adverse determinations or coverage denials. For example, a member feels his/her cost should be reduced from what is determined by the Plan (i.e. a drug is covered on the Tier 3 and the member feels the drug should be covered as under Tier 1 or Tier 2). The Department of Employee Insurance is responsible for Administrative Appeals.

HOW TO FILE an Internal Appeal for Adverse Determination or Coverage Denial

Initial Complaint – a member should always contact the Third Party Administrator's Customer Service Department first at 877-KYSPIRIT. Many problems can be resolved the same day. If not, the member services representative will investigate and contact the member with the findings and any action taken to resolve the complaint. If a member's complaint is related to a denial of coverage or other decision by the Third Party Administrator, the member may file an appeal.

Internal Appeal - If the complaint is not resolved to the satisfaction of the member, on the initial complaint to the Third Party Administrator's Customer Service Department, the *employee* may request an internal appeal. A request for an internal appeal must be submitted in writing within 180 days of receipt of a denial letter to:

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

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

The letter should be sent to the address listed above and should include at a minimum the following information:

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

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

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

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

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

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

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

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

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

HOW TO FILE an External Appeal for Adverse Determination or Coverage Denial

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

Your External Review Rights

A request for an external review of Express Scripts' denial can be filed by you, an authorized representative, or your provider acting on your behalf and with your permission. Express Scripts must receive the request for an external review within 60 calendar days of the date you received this letter.

If someone requests the external review on your behalf, you must give them written permission to act for you, and this permission must be sent to Express Scripts. You must also provide Express Scripts with written permission to release your medical records to the independent review entity (IRE).

If your physician believes that waiting for a standard external review decision will seriously jeopardize your health, he or she can request an expedited external review. This can be submitted by calling the phone number provided on your benefit card. Expedited external review decisions will be issued within 24 hours of the IRE's receipt of all information required from us. A standard external review decision will be issued within 21 calendar days of the IRE's receipt of all information from us. Express Scripts will pay the cost of the external review. You will be responsible for a filing fee of \$25, which will be billed to you by the IRE. This fee will be waived or refunded if the decision is in your favor, and it can be waived or refunded if the IRE believes it will create a financial hardship for you. The IRE's decision is binding on Express Scripts.

Please send your written request for an external review to the following address:

Express Scripts, Inc.
Clinical Appeals - CKY
Mail Route BL0390
6625 W. 78th Street
Bloomington, MN 55439

EXPEDITED EXTERNAL APPEAL

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

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

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

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

COVERAGE DENIALS

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

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

ADMINISTRATIVE APPEAL

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

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

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.

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).

Legal and other notices may be found in the corresponding Medical SPD and on the KEHP website.

NOTICE OF PRIVACY PRACTICES (SUMMARY)

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

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

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

The HIPAA Privacy Rule protects only PHI. Generally, PHI is individually identifiable health information, including demographics information, collected from you or created or received by a health care provider, health care clearing house, or your employer on behalf of a group health plan that relates to: 1) your past, present, or future physical or mental health or condition; 2) the provisions or health care to you; or 3) past, present, or future payment for provisions of health care to you. **DEI does not maintain information regarding your specific medical condition but does maintain PHI related to demographic information and other information that is necessary for determining eligibility and enrollment in the KEHP.** If you have any questions about this Notice or about our Privacy Practices, please visit <http://personnel.ky.gov/dei/hipaa.htm> or contact Department of Employee Insurance, Attn; HIPAA Privacy Officer, 501 High Street, 2nd Floor, Frankfort, Kentucky 40601. The effective date of this Notice is January 1, 2011.

DEI Responsibilities

We are required by law to: 1) maintain the privacy of your PHI; 2) provide you with certain rights with respect to your PHI; 3) provide you with a copy of this Notice of our legal duties and privacy practices with respect to your PHI; 4) follow Breach accounting and notification requirements; and 5) follow the terms of the Notice that is currently in effect. We reserve the right to change the terms of Notice and to make new provisions regarding your PHI that we maintain, or as required by law.

How DEI May Use and Disclose Your Protected Health Information

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

Special Situations

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

Required Disclosures

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

Other Disclosures

Other disclosures may be made to your personal representatives, spouses and other family members and with written authorization. DEI's HIPAA Forms may be located at <http://personnel.ky.gov/dei/hipaa.htm>.

Participant Rights

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

Breach defined

The Breach Regulations provide a specific definition of "breach" for purposes of the notice obligations. Compliance with the Breach Regulations hinges on understanding this definition and being able to identify "breaches." A "breach" for purposes of the Breach Regulations and the corresponding notice obligation occurs only if (i) there is an acquisition, access, use or disclosure (ii) of unsecured PHI (iii) that violates the HIPAA Privacy Rules relating to use and disclosure of PHI and (iv) that compromises the security or privacy of the unsecured PHI. The definition of "breach" has several moving parts and exceptions. Therefore not every violation of the HIPAA Privacy Rules will constitute a breach for purposes of the Breach Regulations.

Breach Notification Requirements

Following a breach of unsecured protected health information covered entities must provide notification of the breach to affected individuals, the Secretary, U.S. Department of Health & Human Services (HHS) and, in certain circumstances, to the media. In addition, business associates must notify covered entities that a breach has occurred.

1) Individual Notice

DEI shall notify affected individuals following the discovery of a breach of unsecured protected health information. DEI shall provide this individual notice in written form by first-class mail, or alternatively, by e-mail if the affected individual has agreed to receive such notices electronically. If DEI has insufficient or out-of-date contact information for 10 or more individuals, the Administrator must provide substitute individual notice by either posting the notice on the home page of its web site or by providing the notice in major print or broadcast media where the affected individuals likely reside. If the Administrator has insufficient or out-of-date contact information for fewer than 10 individuals, the Administrator may provide substitute notice by an alternative form of written, telephone, or other means.

These individual notifications must be provided without unreasonable delay and in no case later than 60 days following the discovery of a breach and must include, to the extent possible, a description of the breach, a description of the types of information that were involved in the breach, the steps affected individuals should take to protect themselves from potential harm, a brief description of what the Administrator is doing to investigate the breach, mitigate the harm, and prevent further breaches, as well as contact information for the Administrator.

2) Media Notice

When the Administrator experiences a breach affecting more than 500 residents of a State or jurisdiction are, in addition to notifying the affected individuals, it shall provide notice to prominent media outlets serving the State or jurisdiction. Like individual notice, this media notification must be provided without unreasonable delay and in no case later than 60 days following the discovery of a breach and must include the same information required for the individual notice.

3) Notice to the Secretary

In addition to notifying affected individuals and the media (where appropriate), covered entities must notify the Secretary of breaches of unsecured protected health information. Covered entities will notify the Secretary by visiting the HHS web site and filling out and electronically submitting a breach report form. If a breach affects 500 or more individuals, covered entities must notify the Secretary without unreasonable delay and in no case later than 60 days following a breach. If, however, a breach affects fewer than 500 individuals, the Administrator may notify the Secretary of such breaches on an annual basis. Reports of breaches affecting fewer than 500 individuals are due to the Secretary no later than 60 days after the end of the calendar year in which the breaches occurred.

4) Notification by a Business Associate

If a breach of unsecured protected health information occurs at or by a business associate, the business associate must notify the Administrator following the discovery of the breach. A business associate must provide notice to the Administrator without unreasonable delay and no later than 60 days from the discovery of the breach. To the extent possible, the business associate should provide the Administrator with the identification of each individual affected by the breach as well as any information required to be provided by the Administrator in its notification to affected individuals.

Business Associates

Effective February 17, 2010, business associates are required to fully implement the information security safeguards specified by the HIPAA Security Rule. Additionally, pursuant to the HITECH Act business associates must implement written, comprehensive information security programs that address each aspect of the HIPAA Security Rule. Business Associates shall work with the Administrator in pursuit of Breach accounting and notification requirement established by the HITECH Act.

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with DEI or with the Office of Civil Rights of the United States Department of Health and Human Services, electronic mail address: OCRMail@hhs.gov.

To file a complaint with DEI please visit <http://personnel.ky.gov/dei/hipaa.htm>. All complaints must be in writing. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Right or with DEI.

**2011 Plan Year
IMPORTANT NOTICE
FROM THE KENTUCKY EMPLOYEES' HEALTH PLAN
ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND *MEDICARE***

Please read this notice carefully and keep it where you can find it. This notice has information about your current *prescription* drug coverage with Kentucky Employees' Health Plan and about your options under *Medicare's* *prescription* drug coverage.

This information can help you decide whether or not you want to join a *Medicare* drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering *Medicare prescription* drug coverage in your area. Information about where you can get help to make decisions about your *prescription* drug coverage is at the end of this notice.

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

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

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

When Can You Join A *Medicare* Drug Plan?

You can join a *Medicare* drug plan when you first become eligible for *Medicare* and each year from November 15th through December 31st. However, if you lose your current creditable *prescription* drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a *Medicare* drug plan.

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

If you decide to join a *Medicare* drug plan, your current Kentucky Employees Health Plan coverage will be affected. For additional information about your Kentucky Employees' Health Plan *Prescription* Drug coverage please see the 2011 *Prescription* Drug Summary Plan Descriptions. Please also see pages 7- 9 of the CMS Disclosure of *Creditable Coverage To Medicare* Part D Eligible Individuals Guidance (available at <http://www.cms.hhs.gov/CreditableCoverage/>), which outlines the *prescription* drug plan provisions/options that *Medicare* eligible individuals may have available to them when they become eligible for *Medicare* Part D.

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

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

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

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

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

Use the contact information listed below for further information the Personnel Cabinet, Department of Employee Insurance, 501 High Street, 2nd Floor, Frankfort, Kentucky 40601. 502-564-0358 or toll free at (888) 581-8834. You may also visit the Department of Employee Insurance website at <http://personnel.ky.gov/dei/> and Kentucky Employees Health Plan 2011 *Prescription* Drug Summary Plan Descriptions.

Note:

You'll get this notice each year. You will also get it before the next period you can join a *Medicare* drug plan, and if this coverage through Kentucky Employees Health Plan changes. You also may request a copy of this notice at any time.

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

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about *Medicare* plans that offer *prescription* drug coverage is in the "*Medicare & You*" handbook. You'll get a copy of the handbook in the mail every year from *Medicare*. You may also be contacted directly by *Medicare* drug plans.

For more information about *Medicare prescription* drug coverage:

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

If you have limited income and resources, extra help paying for *Medicare prescription* drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Contact Information:

Date: January 1, 2011
Name of Entity/Sender: Kentucky Employees' Health Plan
Contact--Position/Office: Department of Employee Insurance
Address: 501 High Street, 2nd Floor, Frankfort, Kentucky 40601
Phone Number: 502-564-0358 or toll free at (888) 581-8834

DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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 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 not 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.

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

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

Employee means you, as an *employee*, when you are permanently employed and paid a salary or earnings and are in an *active status* at your *employer's* place of business.

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

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

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

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

Generic means a Tier 1 drug that is manufactured, distributed and available from several pharmaceutical manufacturers and identified by the chemical name; or as defined by the national pricing standard used by the *Plan Manager*. *Generic prescription drugs* have the same active ingredients in the same dosage form and strength as their brand-name counterparts. The U.S. Food and Drug Administration (FDA) approves both brand-name drugs and *generic* drugs and requires *generic* drugs to have the same active ingredients. Kentucky law requires the *pharmacy* to dispense the *generic* drug if a *generic* drug is available. Generic drugs are therapeutically equivalent to brand-name drugs whose patents have expired.

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

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

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

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

1. Generally prescribed for treatment of long-term chronic *illness* or *bodily injuries*; and
2. Purchased from the *pharmacy* contracted by the *Plan Manager* to dispense drugs.

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

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

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

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

Over-the-Counter (OTC) drug – a drug product that does not require a *Prescription* Order under federal

or state law.

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

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

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

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

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

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

Pre-existing condition limitations will be waived or reduced for *pre-existing conditions* that were satisfied under previous *creditable coverage*, and for children under the age of nineteen..

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

1. The name and address of the *covered person* for whom the *prescription* is intended;
2. The type and quantity of the drug, medicine or medication prescribed, and the directions for its use;
3. The date the *prescription* was prescribed; and
4. The name, address and DEA number of the prescribing *physician*.

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

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

1. Provides for support of a covered *employee's* child;
2. Provides for health benefit coverage to the child;
3. Is made under state domestic relations law;

4. Relates to benefits under this Plan; and
5. Is qualified in that it meets the technical requirements of ERISA or applicable state law.

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

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

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

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

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

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

Tier 1 are generic prescription drug with the same active ingredients in the same dosage form and strength as their brand-name counterparts. The U.S. Food and Drug Administration (FDA) approves both brand-name drugs and generic drugs and requires generic drugs to have the same active ingredients. Kentucky law requires the pharmacy to dispense the generic drug if a generic drug is available. Generic drugs are therapeutically equivalent to brand name drugs whose patents have expired.

Tier 2 are formulary brand-name drugs that have been reviewed and approved by an independent group of doctors and pharmacists, and have been selected for formulary inclusion based on its proven clinical and cost-effectiveness.

Tier 3 are non-formulary brand drugs which are a brand-name prescription drug that has one or more therapeutic alternatives available, either a generic drug or a formulary brand drug. A non-formulary drug is a drug that has been reviewed by the same team of doctors and pharmacists. They have determined that a therapeutically-equivalent and more cost-effective drug is available.

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

Total disability or totally disabled means:

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

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

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

Tricare means 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

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