KENTUCKY EMPLOYEES’ HEALTH PLAN

SUMMARY PLAN DESCRIPTION

For the

LIVINGWELL PPO MEDICAL PLAN

Sponsored by

Commonwealth of Kentucky

Group Number(s): P5941, P6070 and P6077

Plan and Option Number(s): 099/516 and 099/705

Effective: January 1, 2014
NOTICE OF AVAILABILITY OF SUMMARY OF BENEFITS AND COVERAGE (SBC)

Under the Affordable Care Act group health plans must provide clear, consistent and comparable information about health plan benefits and coverage to plan participants and new enrollees. The SBC is available on KEHP’s website, to all applicants (at the time of application), and enrollees, at initial enrollment, and annual enrollment. For more information please contact the Department of Employee Insurance, Member Services Branch (888) 581-8834 or kehp.ky.gov.
YOUR RIGHTS AND RESPONSIBILITIES

As a Humana plan member, you have the right to:

- Be provided with information about the Humana plan, its services and benefits, its providers, and your member rights and responsibilities.

- Privacy and confidentiality regarding your medical care and records. Records pertaining to your health care will not be released without your or your authorized representative’s written permission, except as required by law.

- Discuss your medical record with your physician, and receive upon request a copy of that record.

- Be informed of your diagnosis, treatment choices, including non-treatment, and prognosis in terms you can reasonably expect to understand, and to participate in decision-making about your health care and treatment plan.

- Have a candid discussion with your practitioner about appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.

- Expect reasonable access to medically necessary health care services regardless of race, national origin, religion, physical abilities, or source of payment.

- File a formal complaint, as outlined in the plan’s grievance procedure, and to expect a response to that complaint within a reasonable period of time.

- Be treated with courtesy and respect, with appreciation for your dignity and protection of your right to privacy.

- Make recommendations regarding the Plan’s “rights and responsibilities” policies.

You also have the responsibility to:

- Give the Humana Plan and your health care provider complete and accurate information needed in order to care for you.

- Read and be aware of all material distributed by the plan explaining policies and procedures regarding services and benefits.

- Obtain and carefully consider all information you may need or desire in order to give informed consent for a procedure or treatment.

- Follow the treatment plan agreed on with your health care provider, and to weigh the potential consequences of any refusal to observe those instructions or recommendations.

- Be considerate and cooperative in dealing with the plan providers and to respect the rights of fellow plan members.

- Schedule appointments, arrive on time for scheduled visits, and notify your health care provider if you must cancel or be late for a scheduled appointment.

- Express opinions, concerns, or complaints in a constructive manner.

- Notify the Plan Sponsor (Commonwealth of Kentucky) in writing if you move or change your address or phone number, even if these changes are only temporary.

- Pay all copayments, coinsurance and/or premiums by the date when they are due.

- Be honest and open with your physician and report unexpected changes in your condition in a timely fashion.

- Follow health care facility rules and regulations affecting patient care and conduct.
<table>
<thead>
<tr>
<th><strong>As a Humana plan member, you have the right to:</strong></th>
<th><strong>You also have the responsibility to:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Receive Humana’s Notice of Privacy Practices.</td>
<td>• Carry your Humana identification card with you at all times and use it while enrolled in the Humana Plan.</td>
</tr>
<tr>
<td>• Expect your personal information to be kept secure and used appropriately for payment and health plan operations.</td>
<td></td>
</tr>
<tr>
<td>• Expect Humana to adhere to all privacy and confidentiality policies and procedures.</td>
<td></td>
</tr>
<tr>
<td>• Expect the following activities concerning your personal information:</td>
<td></td>
</tr>
<tr>
<td>➢ Request an accounting of disclosures of personal health information disclosed for reasons outside of payment and health plan operations.</td>
<td></td>
</tr>
<tr>
<td>➢ Receive an authorization form for any proposed use of your personal health information outside of routine payment and health plan operations.</td>
<td></td>
</tr>
<tr>
<td>➢ Request an alternate form of communication of personal health information if the release of a portion or all of the information could endanger life or health.</td>
<td></td>
</tr>
<tr>
<td>➢ Right to complain regarding an alleged breach of privacy.</td>
<td></td>
</tr>
<tr>
<td>➢ Right to agree or object regarding Humana’s intent to release your personal information outside of payment or health plan operations.</td>
<td></td>
</tr>
<tr>
<td>➢ Right to request an amendment or correction of your personal information to a designated record created by Humana.</td>
<td></td>
</tr>
<tr>
<td>➢ Right to request access to inspect and copy information.</td>
<td></td>
</tr>
<tr>
<td>As a Humana plan member, you have the right to:</td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>1. Expect the following activities concerning your personal information continued:</td>
<td></td>
</tr>
<tr>
<td>➢ Right to request Humana to restrict the use and disclosure of your personal information and the right to terminate the restriction request.</td>
<td></td>
</tr>
</tbody>
</table>
INTRODUCTION

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

Welcome to your Kentucky Employees’ Health Plan (KEHP) which is administered by Humana Insurance Company (Humana). KEHP has provided you with this Summary Plan Description (SPD), which outlines your benefits, as well as your rights and responsibilities under this Plan.

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

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

DEFINED TERMS

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

PRIVACY

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

CONTACT INFORMATION

Customer Service Telephone Number:

Customer Service Telephone Number: 1-877-597-7474

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

Claims Appeal Address: Humana Grievance and Appeals
P.O. Box 14546
Lexington, KY 40512-4546
<table>
<thead>
<tr>
<th>TABLE OF CONTENTS</th>
</tr>
</thead>
</table>

**SECTION 1, HEALTH RESOURCES AND PRECERTIFICATION** .............................................. 8  
HEALTH RESOURCES ........................................................................................................ 9  
PRECERTIFICATION .......................................................................................................... 19  
PREDETERMINATION OF BENEFITS ................................................................................... 20  
**SECTION 2, MEDICAL BENEFITS** .................................................................................. 21  
UNDERSTANDING YOUR COVERAGE .................................................................................. 22  
SCHEDULE OF BENEFITS .................................................................................................. 24  
MEDICAL COVERED EXPENSES ....................................................................................... 55  
LIMITATIONS AND EXCLUSIONS ..................................................................................... 74  
COORDINATION OF BENEFITS ........................................................................................ 82  
HEALTH CARE CLAIM PROCEDURES .............................................................................. 85  
**SECTION 3, ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE** ................................. 99  
TERMINATION OF COVERAGE .......................................................................................... 108  
**SECTION 4, GENERAL PROVISIONS AND REIMBURSEMENT/SUBROGATION** ................. 109  
GENERAL PROVISIONS ..................................................................................................... 110  
REIMBURSEMENT/SUBROGATION ..................................................................................... 112  
**SECTION 5, NOTICES** ................................................................................................ 116  
IMPORTANT NOTICE FOR EMPLOYEES AND SPOUSES AGE 65 AND OVER .................. 117  
PRIVACY OF PROTECTED HEALTH INFORMATION ....................................................... 119  
CONTINUATION OF MEDICAL BENEFITS (COBRA) ....................................................... 121  
THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA) .................................................................................................................. 126  
MEDICAL CONVERSION PRIVILEGE ............................................................................. 127  
ADDITIONAL NOTICES .................................................................................................... 128  
MEDICAID AND THE CHILDREN’S HEALTH INSURANCE PROGRAM (CHIP) ................. 130  
PLAN DESCRIPTION INFORMATION ............................................................................. 135  
**SECTION 6, DEFINITIONS** .......................................................................................... 137  
**SECTION 7, ADDITIONAL NOTICES** .......................................................................... 160  
NOTICE TO ENROLLEES CONCERNING TOBACCO ..................................................... 161  
NOTICE OF PRIVACY PRACTICES (SUMMARY) ................................................................ 161  
APPENDIX A 171  
APPENDIX B 173  

Page Number
SECTION 1

HEALTH RESOURCES AND PRECERTIFICATION
HEALTH RESOURCES

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

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

Below is a brief description of this Plan’s Health Resources programs. For additional information or questions regarding any of these programs, please contact the customer service telephone number on the back of your ID card, 1-877-597-7474.

UTILIZATION MANAGEMENT

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

Precertification and Concurrent Review

Utilization review may include precertification and concurrent review.

Precertification for emergency services is not required.

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

If you or your covered dependent are to receive a service which requires precertification, you or your qualified practitioner must contact Humana by telephone or in writing. Refer to the Precertification section for time requirements.

After you or your qualified practitioner have provided Humana with your diagnosis and treatment plan, Humana will:

1. Advise you by telephone, electronically, or in writing if the proposed treatment plan is medically necessary; and

2. Conduct concurrent review as necessary.

If your admission is precertified, benefits are subject to all Plan provisions and are payable as shown on the Schedule of Benefits.

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

If you do not obtain precertification for services being rendered, your benefits may be reduced. Refer to the Precertification section for the applicable penalty. Penalties do not apply to emergency services.

CASE MANAGEMENT

The Case Management program provides a higher level of management and involvement for the seriously ill or injured who need intensive, hands-on support. Case Managers, averaging 18 years of experience in nursing, are there to provide condition-specific education, individual assessment, coordination of services, benefit plan guidance, communication with the patient’s support system, personal support and counseling, and facilitation of discharge planning. Their goal is to contribute to the patient’s sense of well-being, address their quality of life, ease the physical and emotional burdens associated with a major medical event and promote the most positive clinical outcomes possible.

Participants for Case Management are identified through a variety of methods, including referrals from other Health Resources programs and services (e.g. a covered person is referred to a Case Manager by their Personal Nurse).

Case Management is based on the individual’s needs, and may include the following:

- Onsite nurse support at facilities with a high volume of Humana admissions;
- Telephone support for persons admitted to facilities where onsite coverage is not provided;
- Post-discharge follow-up for ongoing needs;
- Assistance in finding options and alternatives, such as community resources, social services, Medicare/Medicaid, pharmaceutical medication programs, etc.;
- Catastrophic Case Management that focuses on high-dollar, high-complexity, catastrophic type illnesses such as trauma, complex surgery, automobile accidents and burn injuries.

TRANSITION OF CARE

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

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

HUMANA HEALTH ALERTS

PREVENTIVE REMINDERS

Humana encourages preventive healthcare and may send you wellness messages and reminders via a phone call (live and voice activated), mail, e-mail or text message. Humana’s messaging campaigns may include, but are not limited to:

- Flu vaccination reminders, targeted to those most at risk;
- Cancer screenings – breast, cervical and colorectal;
- Adolescent vaccination reminders.

GAPS IN CARE

Humana’s clinical rules engine leverages expert medical opinions to identify gaps in care that address potential medical errors and instances of sub-optimal medical treatment.

The established clinical rules compare a patients’ pharmacy, laboratory and claims data to industry standard Quality of Care guidelines in order to identify patients at risk of highly specific patient-centric problems. Examples include: a misdiagnosis, a flawed surgical treatment or medical management, and lack of follow-up care or preventive treatment. In addition, a variety of preventive and pharmacy rules are included such as drug-to-drug interactions and drug-to-disease interactions.

When gaps in care, drug to drug interaction, drug to disease interaction or a preventive reminder is identified, an alert and a message, if appropriate, are generated to communicate the findings through physician and member messaging.
NEONATAL INTENSIVE CARE UNIT (NICU) MANAGEMENT

Specially trained case managers promote the highest standards of care for Neonatal Intensive Care Unit (NICU) infants and they work with you and your family throughout the NICU stay to help you prepare for a smooth transition home.

The Neonatal Case Management program includes:

- Registered nurses experienced in neonatal care.
- Coordination of home health needs.
- Transitional services.
- Parent education.
- Case management services.
- Discharge planning and follow-up.

To contact a NICU program representative, call 1-800-622-9529.

TRANSPLANT MANAGEMENT

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

To contact the Transplant Management team, call 1-866-421-5663.

BARIATRIC MANAGEMENT

The Bariatric Management team, made up of a dedicated team of bariatric specialists, is available to explain your morbid obesity and bariatric surgery benefits and medical necessity criteria. They guide you to facilities and qualified practitioners designated by Humana as approved bariatric services providers and provide you access to pre-surgical online educational video modules. Bariatric Registered Nurses provide Utilization Management by guiding eligible covered persons through the bariatric surgery predetermination process and coordinating care. They provide Bariatric Case Management during the surgery process (both inpatient and outpatient surgeries) through 6 months after surgery, which includes discharge planning and post-surgery home health needs. Support for life long lifestyle change is provided, and access is given, to post-surgical education online video modules.

To contact the Bariatric Management team, call 1-866-486-5295.
MYHUMANA

Go to www.humana.com and click on “Log in or Register” to receive step by step instructions on how to set up your MyHumana page. After you have set up your page, log on anytime to find a participating provider, look up your Plan benefits or check the status of a claim. You can also find prescription drug information, information on specific health conditions, financial tools to help with budgeting for health care and more.

MyHumana Mobile allows you quick access to important information using your mobile device’s browser. If you log in to MyHumana Mobile, using your existing MyHumana login and password, you can access:

- The urgent care center finder;
- Your member ID card detail information; and
- Your spending account balance and transaction information (if you have a Humana spending account).

CONDITION MANAGEMENT

The chronic condition management programs support the physician/patient relationship and care plan, emphasize education, promote self-management, evaluate outcomes to improve your overall health, and offer nurse support.

Humana will contact you if you are eligible for a Chronic Condition Management program. If you have not received a phone call and you need support, you can contact Humana at 1-800-622-9529, select “nurse advice” and then “health planning and support.”

DISEASE MANAGEMENT

Disease management programs have been developed to help covered persons manage specific chronic medical conditions. Clinicians are available 24 hours a day to provide individual guidance through coaching, support and service coordination, to help lessen the day-to-day impact of chronic illnesses.

This Plan’s disease management programs include:

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

- **Cancer (active treatment only):** The cancer management program offers support and educational services to adults with cancer who have begun or are planning to undergo surgery, chemotherapy, radiation therapy or biological therapy, those that have a history of cancer that has recurred and those that have declined further therapy but require supportive management. The program’s oncology care managers have an average of 10 years of professional experience in understanding cancer, its symptoms, side effects and treatments.
- **Chronic Obstructive Pulmonary Disease**: This program focuses on adherence to physicians’ treatment plan, as well as education and goal development. Main focus areas include smoking cessation, diet and exercise, and lung health. Ongoing clinician support also discusses symptoms and warning signs education.

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

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

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

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

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

Specific programs may change at Humana’s sole discretion. Some of the disease management programs may not be available in all areas.

**PERSONAL NURSE®**

In addition to disease-specific programs, Humana also offers Personal Nurse, which supports members with long-term, ongoing health needs and/or any chronic condition. Personal Nurses offers covered persons dealing with a condition or illness, following treatment plans, or needing continued guidance in reaching their long-term health goals, the opportunity to develop a long-term partnership with an experienced registered nurse. Personal Nurses provide both personalized education and guidance to resources to help participants better understand their condition or illness and effectively use their benefits. They also teach the benefits of wellness, prevention and disease avoidance, help identify roadblocks to improved health, motivate and support participants’ efforts to meet goals and refer participants to other Health Resource programs that may meet their needs.
Participants will speak with the same Personal Nurse every time – whether the call is initiated by the nurse or the covered person. Personal Nurses work flexible hours and will provide participants with their direct telephone number. Participants can stay with their Personal Nurse for as long as they remain a member of this Plan.

HUMANABEGINNINGS®

The HumanaBeginnings® program educates and guides expectant mothers to make the best choices to achieve a healthy pregnancy and, ultimately, a healthy baby. Participants are offered guidance by phone from the time Humana is notified of the pregnancy through baby’s first months. Participation is not limited to those covered persons with high-risk pregnancies – it is designed as a resource for all expectant mothers covered under the Plan.

HumanaBeginnings® includes:

- Education, support and encouragement toward healthy behaviors and decisions related to pregnancy, such as nutrition, exercise, smoking and depression screening. Participants learn more about their pregnancy, their baby’s development and how to practice healthy habits during pregnancy.
- Educational materials, including a book and newsletters.
- Guidance for managing health concerns and complications.
- Awareness about premature birth. Women are educated about risk factors, preventive measures and the symptoms of preterm labor.
- Experienced registered nurses who specialize in prenatal care who can address questions and concerns.

A nurse reaches the expectant mother and begins discussions centered on her pregnancy and general health. They plan dates and times for future conversations and follow-up after delivery. Along with scheduled calls, the nurse is available as needed for contact throughout the pregnancy and the postpartum period.

Covered persons can enroll themselves at any time during their pregnancy, but are encouraged to enroll early in their pregnancy in order to get the most from the program. Covered persons can enroll in two ways:

- Online at MyHumana (www.myhumana.com); or
- Calling toll-free 1-888-847-9960.
HUMANAFIRST® NURSE ADVICE LINE

HumanaFirst® is a toll-free, 24-hour medical information line, staffed by registered nurses who are available to answer your health-related questions and help you decide where to best seek treatment. HumanaFirst® offers two lines to support your needs:

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

Health Planning and Support: When planning a future medical procedure, registered nurses are available to help you understand your options, choose providers and use your health benefits wisely. When additional clinical support is needed, the nurses will connect you with specialty programs to address your unique needs.

To contact the Nurse Line, call 1-800-622-9529, choose “Nurse Advice” and then “Immediate Medical Concerns” or “Health Planning and Support”.

ONCOLOGY QUALITY MANAGEMENT

The Oncology Quality Management program is a preauthorization management program for chemotherapy agents, supportive drugs and symptom management drugs. Your oncologist will submit their treatment plan to Humana and it will be reviewed using evidence-based guidelines to ensure it is the most effective treatment plan with the lowest amount of toxicity and side effects.

RADIATION THERAPY MANAGEMENT

Radiation Therapy Management is a one-time authorization for complete radiation oncology treatment plans. This program provides ordering qualified practitioners with the latest medical literature supporting best practices.

• Covered persons can have their radiation therapy performed at any facility that their oncologist directs them to (if you see a PAR provider, covered expenses will be paid under the PAR Provider benefit, if you see a Non-PAR provider, covered expenses will be paid under the Non-PAR provider benefit);

• Physician-to-physician: Clinical appropriateness evaluation and consultation;

• Radiation Therapy Management: lowers long term costs by improving outcomes through a reduction of:
  • Recurring cancers, which can result from ineffective radiation delivery;
  • Secondary cancers caused by unnecessary radiation exposure to healthy tissue;
  • Side effects, which can require additional treatment.

Call the toll-free number on the back of your Humana ID card for radiation therapy management.
HEALTH RESOURCES

RADIOLOGY REVIEW SERVICES

Radiology Review Services offers convenient scheduling of imaging procedures (CT, CTA, MRI, MRA and PET scans). Radiology Review Services are designed to help avoid issues such as inappropriate or unnecessary imaging studies that are costly and inconvenient to the patient by educating ordering physicians on imaging procedures and best practice guidelines before the procedure is scheduled.

Your qualified practitioner should call Humana at the toll-free customer service number on the back of your Humana ID card to initiate the consultation and schedule any imaging procedures.

HUMANAVITALITY PROGRAM

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

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

The rewards may include non-health plan benefits such as merchandise, gift cards, debit cards, discounts or contributions to your health spending account.

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

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

Humana’s agreement with any vendor does not eliminate any of your obligations under this Plan or change any of the terms of this Plan. Humana’s agreement with the vendors and the program may be terminated at any time.

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

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

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

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


You will work with a personal health coach who will motivate and help you lose weight, eat better, quit tobacco, manage stress, avoid back problems, get fit, or maintain your health. You decide how you want to receive support whether that is by phone, e-mail or a scheduled on-line chat.

HumanaVitality® Summary

INTRODUCTION

Welcome to HumanaVitality®, an employer-sponsored Program administered by HumanaVitality, LLC. Eligibility for this Program is determined by your employer.

HumanaVitality® was created to empower you to live a healthy lifestyle by providing you with the tools you’ll need along the way. HumanaVitality® will help you discover how your current lifestyle and daily habits contribute to your overall well-being and will show you how making smart choices can improve your health even more.

Staying active can help you feel energized and maintain a healthier lifestyle. It can earn you Vitality Points™ too. For every HumanaVitality® Engagement activity you complete, you’ll earn points toward Vitality Bucks®. You can use your Vitality Bucks® on brand name merchandise in the HumanaVitality® Mall.

The decision to participate in these programs or activities is voluntary and you may decide to participate anytime during the year.

For questions about whether HumanaVitality® is part of an employer group health plan, you should contact your employer.

For additional information, please contact HumanaVitality® at 1-877-597-7474.
Humana will provide precertification as required by this Plan. It is recommended that you or your provider call 877-597-7474 as soon as possible to receive proper precertification.

The following list represents services and medications that are commonly reviewed. This is not an all-inclusive list we recommend that your physician making a specific request for services verify benefits and authorization requirements prior to providing services;

**INPATIENT MEDICAL AND SURGICAL ADMISSIONS (INCLUDES ACUTE HOSPITAL, LONG TERM ACUTE CARE, REHABILITATION FACILITY, SKILLED NURSING FACILITY AND INPATIENT HOSPICE)**

Humana must be notified at least 7 days in advance of an inpatient admission. If the admission is on an emergency basis, notification must be received within 48 hours or the first business day following the emergency admission.

**TRANSPLANTS**

Humana must be notified prior to receiving transplant services.

**DURABLE MEDICAL EQUIPMENT (DME) AND PROSTHETICS**

Humana must be notified if the purchase or rental of durable medical equipment or prosthetics is expected to be $750 or more.

**MORBID OBESITY - BARIATRIC SURGERY**

Humana must be notified prior to receiving bariatric surgery.

**HOME HEALTH CARE, HOME INFUSION AND HOME HOSPICE**

Humana must be notified prior to receiving home health care, home infusion or home hospice services.

**GENETIC MOLECULAR TESTING**

Humana must be notified prior to receiving genetic molecular testing.

**PHARMACY**

Humana must be notified prior to receiving certain prescription drugs in a qualified practitioner’s office, clinic, outpatient hospital or home setting.

**CHEMOTHERAPY AGENTS, SYMPTOM MANAGEMENT DRUGS AND SUPPORTIVE DRUGS**

Humana must be notified prior to receiving chemotherapy agents, symptom management drugs and supportive drugs.

The precertification penalty does not apply to these services.
RADIATION THERAPY

Humana must be notified prior to receiving radiation therapy.

RADIOLOGY: OUTPATIENT ADVANCED IMAGING (MRI, MRA, PET AND CT SCANS; NUCLEAR STRESS TEST)

Humana must be notified prior to receiving outpatient advanced imaging services.

INPATIENT BEHAVIORAL HEALTH (INCLUDING ACUTE CARE AND PARTIAL HOSPITALIZATION)

Humana must be notified at least 7 days in advance of an inpatient behavioral health admission. If the admission is on an emergency basis, notification must be received within 48 hours or the first business day following the emergency admission.

OUTPATIENT BEHAVIORAL HEALTH THERAPY (INCLUDES CLINIC AND INTENSIVE OUTPATIENT THERAPY)

Humana must be notified prior to receiving outpatient behavioral health therapy.

PRECERTIFICATION PENALTY FOR TRANSPLANT SERVICES

If precertification is not received, transplant services will not be covered.

Penalties do not apply to any applicable Plan deductibles or out-of-pocket limits.

Penalties do not apply to emergency services.

PRECERTIFICATION PENALTY FOR ALL OTHER SERVICES

If precertification is not received, benefits will not be covered.

Penalties do not apply to any applicable Plan deductibles or out-of-pocket limits.

Penalties do not apply to emergency services.

PREDETERMINATION OF BENEFITS

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

If treatment is to commence more than 90 days after the date treatment is authorized, Humana will require you to submit another treatment plan.
SECTION 2

MEDICAL BENEFITS
PARTICIPATING AND NON-PARTICIPATING PROVIDERS

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

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

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

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

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

HUMANA/CHOICECARE PPO PAR PROVIDER DIRECTORY

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

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

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

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

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

IMPORTANT INFORMATION ABOUT PLAN BENEFITS

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

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

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

<table>
<thead>
<tr>
<th>DEDUCTIBLES, COINSURANCE, OUT-OF-POCKET LIMITS, LIFETIME MAXIMUM BENEFIT AND OFFICE VISIT COPAYMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>BENEFIT FEATURES</td>
</tr>
<tr>
<td>Individual Deductible</td>
</tr>
<tr>
<td>Family Deductible</td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>COINSURANCE</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>The Plan pays 80%, you pay 20%.</td>
<td>The Plan pays 60%, you pay 40%.</td>
</tr>
</tbody>
</table>

| Individual Out-of-Pocket Limit (Includes Deductible) | $2,500 per covered person | $5,000 per covered person |
DEDUCTIBLES, COINSURANCE, OUT-OF-POCKET LIMITS, LIFETIME MAXIMUM BENEFIT AND OFFICE VISIT COPAYMENTS

<table>
<thead>
<tr>
<th>BENEFIT FEATURES</th>
<th>PAR PROVIDER BENEFIT (IN-NETWORK)</th>
<th>NON-PAR PROVIDER BENEFIT (OUT-OF-NETWORK)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Out-of-Pocket Limit (Includes Deductible)</td>
<td>$5,000 per covered family</td>
<td>$10,000 per covered family</td>
</tr>
</tbody>
</table>

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

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

If you and your covered dependents use a combination of PAR and Non-PAR providers, the PAR and Non-PAR deductible amounts will accumulate separately and do not cross apply.

If you and your covered dependents use a combination of PAR and Non-PAR providers, the PAR and Non-PAR out-of-pocket amounts will accumulate separately and do not cross apply.

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

<table>
<thead>
<tr>
<th>Lifetime Maximum Benefit</th>
<th>Unlimited</th>
<th>Unlimited</th>
</tr>
</thead>
</table>

| Qualified Practitioner Primary Care Physician (PCP) Office Visit Copayment | $25 | Not applicable |

| Qualified Practitioner Specialist Office Visit Copayment | $45 | Not applicable |
### DEDUCTIBLES, COINSURANCE, OUT-OF-POCKET LIMITS, LIFETIME MAXIMUM BENEFIT AND OFFICE VISIT COPAYMENTS

<table>
<thead>
<tr>
<th>BENEFIT FEATURES</th>
<th>PAR PROVIDER BENEFIT (IN-NETWORK)</th>
<th>NON-PAR PROVIDER BENEFIT (OUT-OF-NETWORK)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

One *copayment* will be taken per day (same day and same site as office visit) per servicing *provider*, unless otherwise indicated in this Schedule.

### ROUTINE/PREVENTIVE CHILD CARE SERVICES

**BIRTH TO AGE 18**

*Services Received at a Clinic or Outpatient Hospital*

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PAR PROVIDER BENEFIT (IN-NETWORK)</th>
<th>NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine/Preventive Child Care Examination (including routine vision and hearing screening when part of a <em>qualified practitioner primary care physician</em> examination)</td>
<td>Payable at 100%</td>
<td>60% after <em>deductible</em></td>
</tr>
<tr>
<td><em>Childhood Obesity</em> Examination (children between the ages of 3 and 18 only)</td>
<td>Payable at 100%</td>
<td>60% after <em>deductible</em></td>
</tr>
</tbody>
</table>

*Members utilizing Non-PAR Providers are subject to *balance billing.*
## ROUTINE/PREVENTIVE CHILD CARE SERVICES
### BIRTH TO AGE 18
(Services Received at a Clinic or Outpatient Hospital)

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PAR PROVIDER BENEFIT (IN-NETWORK)</th>
<th>NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Childhood Obesity</em> Nutritional Counseling with a Nutritionist or Dietician who is a Registered Dietician (children between the ages of 3 and 18 only)</td>
<td>Payable at 100%</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><em>Childhood Obesity</em> Examinations/Nutritional Counseling Limits</td>
<td>8 visits per eligible covered dependent child per calendar year</td>
<td></td>
</tr>
<tr>
<td>Routine/Preventive Child Care Laboratory</td>
<td>Payable at 100%</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Routine/Preventive Child Care X-ray</td>
<td>Payable at 100%</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Routine/Preventive Child Care Immunizations</td>
<td>Payable at 100%</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Routine/Preventive Child Care Immunizations (e.g. HPV Vaccine, Meningitis Vaccine, etc.)</td>
<td>Payable at 100%</td>
<td>60% after deductible</td>
</tr>
</tbody>
</table>

Immunizations are covered based on the recommendations by the Department of Health and Human Services - Centers for Disease Control and Prevention.
### ROUTINE/PREVENTIVE CHILD CARE SERVICES

**BIRTH TO AGE 18**

*(Services Received at a Clinic or Outpatient Hospital)*

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PAR PROVIDER BENEFIT (IN-NETWORK)</th>
<th>NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine/Preventive Child Care Flu/Pneumonia Immunizations</td>
<td>Payable at 100%</td>
<td>60% after <em>deductible</em></td>
</tr>
</tbody>
</table>

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

### ROUTINE/PREVENTIVE ADULT CARE SERVICES

**AGE 18 AND OVER**

*(Services Received at a Clinic or Outpatient Hospital)*

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PAR PROVIDER BENEFIT (IN-NETWORK)</th>
<th>NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine/Preventive Adult Care Examination (including routine vision and hearing screening when part of a qualified practitioner primary care physician examination)</td>
<td>Payable at 100%</td>
<td>60% after <em>deductible</em></td>
</tr>
<tr>
<td>Routine/Preventive Adult Care Laboratory</td>
<td>Payable at 100%</td>
<td>60% after <em>deductible</em></td>
</tr>
<tr>
<td>Routine/Preventive Adult Care X-ray</td>
<td>Payable at 100%</td>
<td>60% after <em>deductible</em></td>
</tr>
</tbody>
</table>
## ROUTINE/PREVENTIVE ADULT CARE SERVICES
### AGE 18 AND OVER
*(Services Received at a Clinic or Outpatient Hospital)*

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PAR PROVIDER BENEFIT (IN-NETWORK)</th>
<th>NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine/Preventive Adult Care Immunizations (e.g. Shingles Vaccine, Meningitis Vaccine, HPV Vaccine, etc.)</td>
<td>Payable at 100%</td>
<td>60% after <em>deductible</em></td>
</tr>
<tr>
<td>Immunizations are covered based on the recommendations by the Department of Health and Human Services - Centers for Disease Control and Prevention</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine/Preventive Adult Care Flu/Pneumonia Immunizations</td>
<td>Payable at 100%</td>
<td>60% after <em>deductible</em></td>
</tr>
<tr>
<td>Routine/Preventive Adult Care Mammograms</td>
<td>Payable at 100%</td>
<td>60% after <em>deductible</em></td>
</tr>
<tr>
<td>Routine/Preventive Adult Care Pap Smears</td>
<td>Payable at 100%</td>
<td>60% after <em>deductible</em></td>
</tr>
</tbody>
</table>
# ROUTINE/PREVENTIVE ADULT CARE SERVICES

**AGE 18 AND OVER**

*(Services Received at a Clinic or Outpatient Hospital)*

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PAR PROVIDER BENEFIT (IN-NETWORK)</th>
<th>NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine/Preventive Adult Care Colonoscopy, Proctosigmoidoscopy and Sigmoidoscopy Screenings (including related services) (performed at an outpatient facility, ambulatory surgical center or clinic location). Removal of polyps during a routine colonoscopy will be payable as a preventive procedure.</td>
<td>Payable at 100%</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Prostate Specific Antigen (PSA) Testing</td>
<td>Payable at 100%</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Physical Examination Yearly Visit Limits</td>
<td>1 visit per <em>covered person</em></td>
<td></td>
</tr>
<tr>
<td>Well Woman Examination Yearly Visit Limits</td>
<td>1 visit per <em>covered person</em></td>
<td></td>
</tr>
</tbody>
</table>

Sometimes during the course of a screening procedure (routine wellness or preventive care), abnormalities or problems may be identified that require immediate intervention or additional diagnosis. If this occurs, and *your provider* performs additional necessary procedures, the *service* will be considered diagnostic and/or surgical, rather than screening, depending on the *claim* for the *services* submitted by *your provider*. This may result in a possible difference in *your copayment* and/or *coinsurance*.

| Breast Feeding Counseling                             | Payable at 100%                    | 60% after deductible                      |
ROUTINE/PREVENTIVE ADULT CARE SERVICES
AGE 18 AND OVER
(Services Received at a Clinic or Outpatient Hospital)

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PAR PROVIDER BENEFIT (IN-NETWORK)</th>
<th>NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Feeding Support and Supplies</td>
<td>Payable at 100%</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Contraceptive Methods - devices (e.g. IUD or diaphragms), injections, implant insertion/removal, Sterilization and tubal ligation</td>
<td>Payable at 100%</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>For information on prescription drug coverage for birth control pills/patches, abortifacients, spermicide, the morning after pill and condoms, please see your prescription drug benefits.</td>
<td>If services are not to prevent pregnancy, then they are payable the same as any other sickness.</td>
<td>If services are not to prevent pregnancy, then they are payable the same as any other sickness.</td>
</tr>
</tbody>
</table>

Age limits do not apply to routine mammograms and pap smears.

To the extent required by the Affordable Care Act, age limits do not apply to breast feeding counseling, breast feeding support and supplies, contraceptive methods and sterilization.

*Members utilizing Non-PAR Providers are subject to balance billing.
### ROUTINE VISION SERVICES

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PAR PROVIDER BENEFIT (IN-NETWORK)</th>
<th>NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Vision Examination</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Routine Vision Refraction</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Eyeglass Frames and Lenses and Contact Lenses</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

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

### HEARING AIDS AND RELATED SERVICES

**BIRTH THROUGH AGE 17**

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PAR PROVIDER BENEFIT (IN-NETWORK)</th>
<th>NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Hearing Examination and Testing</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

**Hearing Aids and Fitting**

- 80% after deductible
- 60% after deductible

*Members utilizing Non-PAR Providers are subject to *balance billing*.****
## QUALIFIED PRACTITIONER SERVICES
(Non-Routine/Non-Preventive Care Services)

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PAR PROVIDER BENEFIT (IN-NETWORK)</th>
<th>NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic Office Examination at a Clinic, including Second Surgical Opinion – Qualified Practitioner Primary Care Physician</td>
<td>100% after a $25 copayment</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Diagnostic Office Examination at a Clinic, including Second Surgical Opinion - Qualified Practitioner Specialist</td>
<td>100% after a $45 copayment</td>
<td>60% after deductible</td>
</tr>
</tbody>
</table>

If an office examination is billed from an *outpatient* location, the *services* will be payable the same as an office examination at a clinic.

<table>
<thead>
<tr>
<th></th>
<th>PAR PROVIDER BENEFIT (IN-NETWORK)</th>
<th>NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic Laboratory at a Clinic</td>
<td>Payable at 100%</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Diagnostic X-ray at a Clinic (other than advanced imaging)</td>
<td>Payable at 100%</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Independent Laboratory</td>
<td>Payable at 100%</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Advanced Imaging at a Clinic</td>
<td>Payable at 100%</td>
<td>60% after deductible</td>
</tr>
</tbody>
</table>

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

---

33
## QUALIFIED PRACTITIONER SERVICES  
(Non-Routine/Non-Preventive Care Services)

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PAR PROVIDER BENEFIT (IN-NETWORK)</th>
<th>NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy Testing at a Clinic</td>
<td>100% after the applicable qualified practitioner office visit copayment</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Allergy Serum/Vials at a Clinic</td>
<td>100% after the applicable qualified practitioner office visit copayment</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Allergy Injections at a Clinic</td>
<td>100% after a $25 copayment</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Injections at a Clinic (other than routine immunizations, flu or pneumonia injections, contraceptive injections for birth control reasons and allergy injections)</td>
<td>100% after a $25 copayment</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Anesthesia at a Clinic</td>
<td>100% after the applicable qualified practitioner office visit copayment</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Surgery at a Clinic (including Qualified Practitioner, Assistant Surgeon and Physician Assistant)</td>
<td>100% after the applicable qualified practitioner office visit copayment</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Medical and Surgical Supplies</td>
<td>Payable at 100%</td>
<td>60% after deductible</td>
</tr>
</tbody>
</table>

*Copayments* for allergy injections are applied per visit (highest *copayment* will apply).

*Members utilizing Non-PAR Providers are subject to *balance billing.*
QUALIFIED PRACTITIONER SERVICES  
(Non-Routine/Non-Preventive Care Services)

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PAR PROVIDER BENEFIT (IN-NETWORK)</th>
<th>NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eyeglasses or Contact Lenses after Cataract Surgery (initial pair only) (Clinic)</td>
<td>100% after the applicable qualified practitioner office visit copayment</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Eyeglasses or Contact Lenses after Cataract Surgery (initial pair only) (Inpatient or Outpatient)</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Diabetic Counseling and Diabetic Nutritional Counseling (Diabetes Self-Management Training) (all places of service)</td>
<td>Payable the same as any other sickness.</td>
<td>Payable the same as any other sickness.</td>
</tr>
<tr>
<td>*Diabetes Supplies</td>
<td>Payable the same as medical supplies.</td>
<td>Payable the same as medical supplies.</td>
</tr>
</tbody>
</table>

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

DENTAL/ORAL SURGERIES COVERED UNDER THE MEDICAL PLAN

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PAR PROVIDER BENEFIT (IN-NETWORK)</th>
<th>NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental/Oral Surgeries</td>
<td>Payable the same as any other sickness.</td>
<td>Payable the same as any other sickness.</td>
</tr>
</tbody>
</table>

Please refer to the Medical Covered Expenses section, Dental/Oral Surgeries Covered Under the Medical Plan, for a list of oral surgeries covered under this benefit.
## REVERSAL OF STERILIZATION AND ABORTIONS

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PAR PROVIDER BENEFIT</th>
<th>NON-PAR PROVIDER BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reversal of Sterilization</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Life Threatening Abortions</td>
<td>Payable the same as any other sickness.</td>
<td>Payable the same as any other sickness.</td>
</tr>
<tr>
<td>Elective Abortions</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Vasectomy</td>
<td>Payable the same as any other sickness.</td>
<td>Payable the same as any other sickness.</td>
</tr>
</tbody>
</table>

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

## MATERNITY

*(Normal, C-Section and Complications)*

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PAR PROVIDER BENEFIT (IN-NETWORK)</th>
<th>NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital Room and Board and Ancillary Facility Services</td>
<td>Payable the same as any other sickness.</td>
<td>Payable the same as any other sickness.</td>
</tr>
<tr>
<td>Birthing Center Room and Board and Ancillary Services</td>
<td>Payable the same as any other sickness.</td>
<td>Payable the same as any other sickness.</td>
</tr>
<tr>
<td>Qualified Practitioner Services (Office visit copayment will apply to the initial maternity visit only.)</td>
<td>Payable the same as any other sickness.</td>
<td>Payable the same as any other sickness.</td>
</tr>
<tr>
<td>Dependent Daughter Maternity</td>
<td>Payable the same as any other sickness.</td>
<td>Payable the same as any other sickness.</td>
</tr>
</tbody>
</table>
### MATERNITY
(Normal, C-Section and Complications)

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PAR PROVIDER BENEFIT (IN-NETWORK)</th>
<th>NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newborn Inpatient Qualified Practitioner Services</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Newborn Inpatient Facility Services</td>
<td>80% The newborn deductible and copayment will be waived for facility services.</td>
<td>60% The newborn deductible and copayment will be waived for facility services.</td>
</tr>
</tbody>
</table>

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

### INPATIENT SERVICES

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PAR PROVIDER BENEFIT (IN-NETWORK)</th>
<th>NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital Room and Board and Ancillary Facility Services</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Qualified Practitioner Inpatient Hospital Visit</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Qualified Practitioner Inpatient Surgery and Anesthesia</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Qualified Practitioner Inpatient Pathology and Radiology</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
</tbody>
</table>
### INPATIENT SERVICES

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PAR PROVIDER BENEFIT (IN-NETWORK)</th>
<th>NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private Duty Nursing</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

### SKILLED NURSING SERVICES

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PAR PROVIDER BENEFIT (IN-NETWORK)</th>
<th>NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled Nursing Room and Board and Ancillary Facility Services</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Skilled Nursing Facility Yearly Limits</td>
<td>30 day(s) per covered person</td>
<td></td>
</tr>
<tr>
<td>Skilled Nursing Qualified Practitioner Visit</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
</tbody>
</table>
## OUTPATIENT AND AMBULATORY SURGICAL CENTER SERVICES

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PAR PROVIDER BENEFIT (IN-NETWORK)</th>
<th>NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory Surgical Center Facility Services</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Ambulatory Surgical Center Ancillary Services</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Outpatient Hospital Facility Surgical Services</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Outpatient Hospital Facility Non-Surgical Services (e.g. clinic facility services; observation)</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Outpatient Hospital Surgical and Non-Surgical Ancillary Services (e.g. supplies; medication; anesthesia)</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Outpatient Hospital Facility Diagnostic Laboratory and X-ray (other than advanced imaging)</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Preadmission Testing</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Outpatient Hospital Facility Advanced Imaging</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
</tbody>
</table>

*Members utilizing Non-PAR Providers are subject to balance billing.
### OUTPATIENT AND AMBULATORY SURGICAL CENTER SERVICES

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PAR PROVIDER BENEFIT (IN-NETWORK)</th>
<th>NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Hospital and Ambulatory Surgical Center Qualified Practitioner Visit</strong></td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>Outpatient Hospital and Ambulatory Surgical Center Surgery</strong> (including surgeon; assistant surgeon; and physician assistant) and Anesthesia</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>Outpatient Hospital and Ambulatory Surgical Center Pathology and Radiology</strong></td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
</tbody>
</table>

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

### EMERGENCY AND URGENT CARE SERVICES

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PAR PROVIDER BENEFIT (IN-NETWORK)</th>
<th>NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emergency Room Facility Services</strong> (true emergency)</td>
<td>$150 copayment then 80% after deductible</td>
<td>Payable the same as PAR Provider Benefit.</td>
</tr>
<tr>
<td>If you are admitted to the hospital, the copayment will be waived.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

*Members utilizing Non-PAR Providers are subject to balance billing.*
EMERGENCY AND URGENT CARE SERVICES

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PAR PROVIDER BENEFIT (IN-NETWORK)</th>
<th>NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Room Ancillary Services (e.g. laboratory; x-ray; supplies) (true emergency)</td>
<td>$150 copayment then 80%</td>
<td>Payable the same as PAR Provider Benefit.</td>
</tr>
<tr>
<td>Emergency Room All Physician Services (including Emergency Room Physician, Radiologist, Pathologist, Anesthesiologist and ancillary services billed by an Emergency Room Physician) (true emergency)</td>
<td>80% after deductible</td>
<td>Payable the same as PAR Provider Benefit.</td>
</tr>
<tr>
<td>Emergency Room Facility Services (non-emergency)</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Emergency Room Ancillary Services (e.g. laboratory; x-ray; supplies) (non-emergency)</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Emergency Room All Physician Services (including Emergency Room Physician, Radiologist, Pathologist, Anesthesiologist and ancillary services billed by an Emergency Room Physician) (non-emergency)</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

*Members utilizing Non-PAR Providers are subject to balance billing.
<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PAR PROVIDER BENEFIT (IN-NETWORK)</th>
<th>NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care Center (facility, ancillary services and qualified practitioner services)</td>
<td>100% after a $50 copayment</td>
<td>Payable the same as PAR Provider Benefit.</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PAR PROVIDER BENEFIT (IN-NETWORK)</th>
<th>NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice Inpatient Room and Board and Ancillary Services</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Hospice Outpatient (including hospice home visits)</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Hospice Qualified Practitioner Visit</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

*Members utilizing Non-PAR Providers are subject to balance billing.
# SCHEDULE OF BENEFITS (continued)

## HOME HEALTH CARE SERVICES

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PAR PROVIDER BENEFIT (IN-NETWORK)</th>
<th>NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Care Services</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Home Health Care Yearly Limits</td>
<td>60 visit(s) per covered person</td>
<td></td>
</tr>
</tbody>
</table>

Home therapy benefits will be reimbursed under the home health care benefit.

If therapies are done in the home (such as physical or occupational therapy), these therapy services will apply to the home health care limits.

If therapies and home health visits are done on the same day the services will track as one visit per day.

| Home Health Care Ancillary Services (excluding durable medical equipment, prosthetics and private duty nursing) | 80% after deductible | 60% after deductible |

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

## DURABLE MEDICAL EQUIPMENT (DME)

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PAR PROVIDER BENEFIT (IN-NETWORK)</th>
<th>NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Durable Medical Equipment (DME) (Clinic)</td>
<td>100% after the applicable qualified practitioner office visit copayment</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME) (Inpatient or Outpatient)</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
</tbody>
</table>
## DURABLE MEDICAL EQUIPMENT (DME)

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PAR PROVIDER BENEFIT (IN-NETWORK)</th>
<th>NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prosthesis (Clinic)</td>
<td>100% after the applicable qualified practitioner office visit copayment</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Prosthesis (Inpatient or Outpatient)</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Wigs</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

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

## SPECIALTY DRUGS

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PAR PROVIDER BENEFIT</th>
<th>NON-PAR PROVIDER BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty Drugs (Qualified Practitioner’s Office Visit, Home Health Care, Freestanding Facility and Urgent Care)</td>
<td>Payable the same as any other sickness.</td>
<td>Payable the same as any other sickness.</td>
</tr>
<tr>
<td>Specialty Drugs (Emergency Room, Ambulance, Inpatient Hospital, Outpatient Hospital and Skilled Nursing Facility)</td>
<td>Payable the same as any other sickness.</td>
<td>Payable the same as any other sickness.</td>
</tr>
</tbody>
</table>
## AMBULANCE SERVICES

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PAR PROVIDER BENEFIT (IN-NETWORK)</th>
<th>NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ground Ambulance</td>
<td>80% after deductible</td>
<td>Payable the same as PAR Provider Benefit per billed charges</td>
</tr>
<tr>
<td>Air Ambulance</td>
<td>80% after deductible</td>
<td>Payable the same as PAR Provider Benefit per billed charges</td>
</tr>
</tbody>
</table>

## MORBID OBESITY SERVICES

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PAR PROVIDER BENEFIT (IN-NETWORK)</th>
<th>NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morbid Obesity</td>
<td>Payable the same as any other sickness.</td>
<td>Payable the same as any other sickness.</td>
</tr>
</tbody>
</table>

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

The following service will be covered under the morbid obesity benefit: examinations/qualified practitioner visits, laboratory and x-ray services and other diagnostic testing, psychological counseling for obesity surgery, bariatric surgery, inpatient facility services, outpatient facility services, home health service, nutritional counseling, and durable medical equipment.
### OBESITY SERVICES

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PAR PROVIDER BENEFIT</th>
<th>NON-PAR PROVIDER BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obesity</td>
<td>Payable the same as any other sickness.</td>
<td>Payable the same as any other sickness.</td>
</tr>
</tbody>
</table>

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

### TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ)

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PAR PROVIDER BENEFIT (IN-NETWORK)</th>
<th>NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Temporomandibular Joint Dysfunction (TMJ) (Other than Splint/Appliances)</td>
<td>Payable the same as any other sickness.</td>
<td>Payable the same as any other sickness.</td>
</tr>
<tr>
<td>Temporomandibular Joint Dysfunction (TMJ) Splint/Appliances</td>
<td>Payable the same as any other sickness.</td>
<td>Payable the same as any other sickness.</td>
</tr>
</tbody>
</table>

### DENTAL INJURY SERVICES

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PAR PROVIDER BENEFIT (IN-NETWORK)</th>
<th>NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Injuries</td>
<td>Payable the same as any other sickness.</td>
<td>Payable the same as any other sickness.</td>
</tr>
</tbody>
</table>

Please see the Medical Covered Expenses section, Dental Injury, for benefit details.

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

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PAR PROVIDER BENEFIT (IN-NETWORK)</th>
<th>NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infertility Counseling and Treatment</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Artificial Means of Achieving Pregnancy</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Sexual Dysfunction/Impotence</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

### THERAPY SERVICES

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PAR PROVIDER BENEFIT (IN-NETWORK)</th>
<th>NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiropractic Examinations</td>
<td>100% after a $25 copayment</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Chiropractic Laboratory and X-ray</td>
<td>Payable at 100%</td>
<td>60% after deductible</td>
</tr>
</tbody>
</table>

Therapy copayments apply to therapy services, regardless of provider specialty (for example, if a Podiatrist is performing physical therapy, the physical therapy copayment will apply).

*Members utilizing Non-PAR Providers are subject to balance billing.*
<table>
<thead>
<tr>
<th>THERAPY SERVICES</th>
<th>MEDICAL SERVICES</th>
<th>PAR PROVIDER BENEFIT (IN-NETWORK)</th>
<th>NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiropractic Manipulations</td>
<td>100% after a $25 copayment</td>
<td>60% after deductible</td>
<td></td>
</tr>
<tr>
<td>Chiropractic Therapy</td>
<td>100% after a $25 copayment</td>
<td>60% after deductible</td>
<td></td>
</tr>
<tr>
<td>Chiropractic Limits</td>
<td>26 visit(s) per covered person, with no more than 1 visit per day</td>
<td>The visit limit applies to the following chiropractic benefits: physical therapy; and manipulations.</td>
<td></td>
</tr>
</tbody>
</table>

If copayments apply to multiple chiropractic services, one copayment will apply per day per servicing provider.

Physical therapy when provided by a chiropractor will deplete the chiropractic limits.

<table>
<thead>
<tr>
<th>Physical Therapy (Clinic and Outpatient)</th>
<th>80% after deductible</th>
<th>60% after deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Therapy Limits</td>
<td>Up to 30 visit(s) per calendar year. May require an authorization.</td>
<td></td>
</tr>
<tr>
<td>Occupational Therapy (Clinic and Outpatient)</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Occupational Therapy Limits</td>
<td>Up to 30 visit(s) per calendar year. May require an authorization.</td>
<td></td>
</tr>
<tr>
<td>Speech Therapy (Clinic and Outpatient)</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Speech Therapy Limits</td>
<td>Up to 30 visit(s) per calendar year. May require an authorization.</td>
<td></td>
</tr>
<tr>
<td>MEDICAL SERVICES</td>
<td>PAR PROVIDER BENEFIT (IN-NETWORK)</td>
<td>NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)</td>
</tr>
<tr>
<td>------------------</td>
<td>-----------------------------------</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td>Cognitive Therapy (Clinic and Outpatient)</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Cognitive Therapy Limits</td>
<td>30 visit(s) per covered person</td>
<td></td>
</tr>
<tr>
<td>Therapy Education (Clinic and Outpatient)</td>
<td>100% after the applicable qualified practitioner office visit copayment</td>
<td>60% after deductible</td>
</tr>
</tbody>
</table>

If copayments apply to multiple therapy services, one copayment will apply per day per servicing provider.

Physical, occupational, speech and cognitive therapies and chiropractic services have separate limits.

<table>
<thead>
<tr>
<th>Physical Therapy</th>
<th>80% after deductible</th>
<th>60% after deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory Therapy and Pulmonary Therapy (Clinic and Outpatient)</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Vision Therapy (eye exercises to strengthen the muscles of the eye) (Clinic and Outpatient)</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Chemotherapy Clinic</td>
<td>100% after the applicable qualified practitioner office visit copayment</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Inpatient/Outpatient</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
</tbody>
</table>
# THERAPY SERVICES

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PAR PROVIDER BENEFIT (IN-NETWORK)</th>
<th>NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiation Therapy Clinic</td>
<td>100% after the applicable qualified practitioner office visit copayment</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Inpatient/Outpatient</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Cardiac Rehabilitation (Phase II)</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Phase I is covered under the inpatient facility benefits.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phase III, an unsupervised exercise program, is not covered.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiac Rehabilitation Limits</td>
<td>30 visit(s) per covered person</td>
<td></td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>HUMANA NATIONAL TRANSPLANT NETWORK (NTN) FACILITY (Payable at the <em>PAR Provider</em> Benefit Level) (IN-NETWORK)</th>
<th>NON-HUMANA NATIONAL TRANSPLANT NETWORK (NTN) FACILITY (Payable at the <em>Non-PAR Provider</em> Benefit Level)* (OUT-OF-NETWORK)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organ Transplant Medical Services</td>
<td>Payable the same as any other sickness.</td>
<td>Payable the same as any other sickness.</td>
</tr>
<tr>
<td>Non-Medical Services - Lodging</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Non-Medical Services - Transportation</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Organ Transplant Medical Services Limits</td>
<td>Lifetime maximum of the <em>Plan</em>.</td>
<td></td>
</tr>
<tr>
<td>Non-Medical Services - Lodging Limits</td>
<td>$10,000 per covered transplant</td>
<td></td>
</tr>
<tr>
<td>Non-Medical Services - Transportation Limits</td>
<td>$10,000 per covered transplant</td>
<td></td>
</tr>
</tbody>
</table>

Lodging and transportation limits are combined.

*Covered expenses* for organ transplants performed at a Humana National Transplant Network facility and at a facility other than a Humana National Transplant Network facility will aggregate toward the *Plan out-of-pocket limits.*

*Members utilizing Non-PAR Providers are subject to *balance billing.*
## BEHAVIORAL HEALTH INPATIENT SERVICES

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PAR PROVIDER BENEFIT (IN-NETWORK)</th>
<th>NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Behavioral Health Room and Board and Ancillary Services</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Inpatient Behavioral Health Professional Services</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Behavioral Health Partial Hospitalization</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Behavioral Health Residential Treatment Facility Services</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Behavioral Health Half-way House Services</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

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

## BEHAVIORAL HEALTH CLINIC, OUTPATIENT AND INTENSIVE OUTPATIENT SERVICES

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PAR PROVIDER BENEFIT (IN-NETWORK)</th>
<th>NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health Therapy Services (Clinic, Outpatient and Intensive Outpatient)</td>
<td>100% after $45 copayment</td>
<td>60% after deductible</td>
</tr>
</tbody>
</table>
### BEHAVIORAL HEALTH CLINIC, OUTPATIENT AND INTENSIVE OUTPATIENT SERVICES

<table>
<thead>
<tr>
<th>Medical Services</th>
<th>PAR Provider Benefit (In-Network)</th>
<th>Non-PAR Provider Benefit* (Out-Of-Network)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnostic Examination</strong></td>
<td>Payable the same as any other sickness.</td>
<td>Payable the same as any other sickness.</td>
</tr>
<tr>
<td>(Clinic)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Laboratory and X-ray</strong></td>
<td>Payable the same as any other sickness.</td>
<td>Payable the same as any other sickness.</td>
</tr>
<tr>
<td>(Clinic and Outpatient)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

### AUTISM SERVICES

<table>
<thead>
<tr>
<th>Medical Services</th>
<th>PAR Provider Benefit (In-Network)</th>
<th>Non-PAR Provider Benefit* (Out-Of-Network)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rehabilitative and Therapeutic Care</strong></td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>Respite Care for covered person age 1-21</strong></td>
<td>80% after deductible, and does not apply to the out-of-pocket maximum</td>
<td>Payable the same as PAR Provider Benefit, and does not apply to the out-of-pocket maximum</td>
</tr>
<tr>
<td><strong>Autism Respite Services Limit</strong></td>
<td>$375 monthly benefit (s) per covered person</td>
<td></td>
</tr>
</tbody>
</table>
### OTHER COVERED EXPENSES

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PAR PROVIDER BENEFIT (IN-NETWORK)</th>
<th>NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Covered Expenses</td>
<td>Payable the same as any other sickness.</td>
<td>Payable the same as any other sickness.</td>
</tr>
</tbody>
</table>

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

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

DEDUCTIBLE

A deductible is a specified dollar amount that must be satisfied, either individually or combined as a covered family, per calendar year before this Plan pays benefits for certain specified services. Only charges which qualify as a covered expense may be used to satisfy the deductible. Copayments do apply toward the deductible. Copayments will continue to be the responsibility of the covered person. The individual and family deductible amounts are stated on the Schedule of Benefits.

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

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

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

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

If you and/or your covered dependents use a combination of PAR and Non-PAR providers, the PAR and Non-PAR deductibles will accumulate separately and do not cross apply.
COINSURANCE

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

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

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

OUT-OF-POCKET LIMIT

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

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

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

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

If you and/or your covered dependents use a combination of PAR and Non-PAR providers, the PAR and Non-PAR out-of-pocket limits will accumulate separately and do not cross apply.

Penalties, copayments and charges above the allowable fee for Non-PAR providers do not apply to the out-of-pocket limits.

LIFETIME MAXIMUM BENEFIT

This Plan does not include a lifetime maximum.
ROUTINE/PREVENTIVE SERVICES

Covered expenses are payable as shown on the Schedule of Benefits and include the preventive services recommended by the U.S. Department of Health and Human Services (HHS) for your plan year as follows:

1. Services with an A or B rating in the current recommendations of the U. S. Preventive Services Task Force (USPSTF). The recommendations by the USPSTF for breast cancer screenings, mammography and preventions issued prior to November 2009 will be considered current.

2. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC).

3. Preventive care for infants, children and adolescents provided in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

4. Preventive care for women provided in the comprehensive guidelines supported by HRSA.

For the recommended preventive services that apply to your plan year, refer to the U.S. Department of Health and Human Services (HHS) website at www.Healthcare.gov or call the customer service telephone number on your identification card.

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

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

HEARING AIDS AND RELATED SERVICES

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

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

QUALIFIED PRACTITIONER SERVICES

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

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

Multiple Surgical Procedures

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

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

No benefits will be payable for incidental procedures.

Surgical Assistant/Assistant Surgeon

Surgical assistants and/or assistant surgeon will be paid at 20% of the covered expense for surgery.

Physician Assistant

Physician assistants will be paid at 20% of the covered expense for surgery.

DENTAL/ORAL SURGERIES COVERED UNDER THE MEDICAL PLAN

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

1. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological examination;
2. Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
3. Reduction of fractures and dislocations of the jaw; and
4. Incision of accessory sinuses, salivary glands or ducts.

FAMILY PLANNING

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

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

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

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).

Newborns

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

Birthing Centers

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

INPATIENT HOSPITAL

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

1. Benefits for room and board when the covered person occupies:
   a. A room with two (2) or more beds, known as a semi-private room or ward; or
   b. A private room. Benefits for a private or single-bed room are limited to the maximum allowable fee charged for a semi-private room in the hospital while a registered bed patient In cases of a facility which only has private rooms, then the average semi-private rate does not apply; or
   c. A private room for the distinct purpose of medical isolation. Coverage is limited to the period of time for which medical isolation is medically necessary. Such cases require specific pre-certification approval by the Plan; or
   d. A bed in a special care unit, including nursing services - a designated unit which is approved by the Plan and has concentrated facilities, equipment, and supportive services for the provision of an intensive level of care for critically ill patients.
2. **Hospital Ancillary services** and supplies including, but not restricted to:
   a. Use of operating, delivery, and treatment rooms and equipment;
   b. Prescription drugs administered to an *inpatient*;
   c. Administration of blood and blood processing, blood clotting elements, factors eight (8) and nine (9) for blood clotting enhancements in relation to hemophilia, and gamma globulin used in the treatment of hepatitis;
   d. Anesthesia, anesthesia supplies and *services* rendered by an *employee* of the *hospital* or through approved contractual arrangements;
   e. Medical and surgical dressings, supplies, casts, and splints;
   f. Diagnostic *services*;
   g. *Therapy services*; and
   h. Special care unit nursing *services*, other than the portion payable under (1)(d) above.

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

**SKILLED NURSING FACILITY**

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

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

1. Begins while *you* or an eligible *dependent* are covered under this *Plan*;
2. Begins after discharge from a *hospital confinement* or a prior covered skilled nursing facility *confinement*;
3. Is necessary for care or treatment of the same *bodily injury* or *sickness* which caused the prior *confinement*; and
4. Occurs while *you* or an eligible *dependent* are under the regular care of a physician.
Skilled nursing facility means only an institution licensed as a skilled nursing facility and lawfully operated in the jurisdiction where located. It must maintain and provide:

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

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

OUTPATIENT AND AMBULATORY SURGICAL CENTER

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

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

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

1. Use of operating room and recovery rooms;
2. Respiratory therapy e.g., oxygen;
3. Administered drugs and medicine;
4. Intravenous solutions;
5. Dressings, including ordinary casts, splints, or trusses;
6. Anesthetics and their administration;
7. Transfusion supplies and equipment;
8. Diagnostic services, including radiology, ultrasound, laboratory, pathology, and approved machine testing e.g., electrocardiogram (EKG);
9. Chemotherapy treatment for proven malignant disease;
10. Radiation therapy; treatment by x-ray, radium or radioactive isotopes; and
11. Renal dialysis treatment for acute or chronic kidney ailment which may include the supportive use of an artificial kidney machine.

EMERGENCY AND URGENT CARE SERVICES

_Emergency_ and _urgent care services_ are payable as shown on the Schedule of Benefits.

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

Care in _hospital emergency_ rooms is subject to the _emergency room copayment_ and/or _coinsurance_ as indicated on the Schedule of Benefits. The _emergency room copayment_ shall not be required if the _covered person_ is admitted, within twenty-four (24) hours, as an _inpatient_ for the condition for which he/she sought _emergency_ care.

If a _covered person_ is admitted to a _hospital_ for _emergency_ care outside the _service area_, the _Plan_, after consultation with the attending physician, may require that the _covered person_ be transferred to a participating _hospital_ as soon as medically feasible.

Benefits are not provided for the use of an _emergency_ room except for treatment of _emergency_ medical conditions, _emergency_ screening and stabilization. All follow-up or continued care, _services_ or prescriptions, must be authorized by the _Plan_, if such approval is required by _your Plan_.

Benefits are provided for _urgent care_ at a freestanding or hospital-based _urgent care_ facility when the _covered person_ is outside the _service area_ or when the primary care _physician_ is unavailable and when care:

1. Is required to prevent serious deterioration in the _covered person's_ health;
2. Could not have been foreseen prior to leaving the _service area_ or during normal office hours;
3. Is not an _emergency_ medical condition, but requires prompt medical attention;
4. Includes, but is not limited to, the treatment of significant injuries as a result of accidents, the relief or elimination of severe pain, or the moderation of an acute illness; and
5. Is obtained in accordance with the benefit booklet _plan delivery system rules_.

62
MEDICAL COVERED EXPENSES (continued)

HOSPICE SERVICES

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

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

Covered expenses are payable for the following hospice services:

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

Hospice care benefits do NOT include:

1. Private duty nursing services when confined in a hospice facility;
2. A confinement not required for pain control or other acute chronic symptom management;
3. Funeral arrangements;
4. Financial or legal counseling, including estate planning or drafting of a will;
5. Homemaker or caretaker services, including a sitter or companion services;
6. Housecleaning and household maintenance;
7. Services of a social worker other than a licensed clinical social worker;
8. Services by volunteers or persons who do not regularly charge for their services; or
9. Services by a licensed pastoral counselor to a member of his or her congregation when services are in the course of the duties to which he or she is called as a pastor or minister.
**Medicare Covered Expenses (continued)**

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

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

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

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

**HOME HEALTH CARE**

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

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

Home health care _provider_ means an agency licensed by the proper authority as a _home health agency_ or Medicare approved as a _home health agency_.

Home health care will not be reimbursed unless this _Plan_ determines:

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

The home health care plan must be reviewed and approved by the _qualified practitioner_ under whose care you are currently receiving treatment for the _bodily injury_ or _sickness_ which requires the home health care.
The home health care plan consists of:

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

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

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

Home health care benefits do not include:

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

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

3. Charges for supervision of home health care providers;

4. Private duty nursing;

5. Durable medical equipment and prosthetics.

**DURABLE MEDICAL EQUIPMENT (DME)**

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

Repair or maintenance of purchased DME is a covered expense if:

1. The manufacturer’s warranty is expired; and

2. Repair or maintenance is not a result of misuse or abuse; and

3. Maintenance is not more frequent than every 6 months; and

4. The repair cost is less than the replacement cost.

Replacement of purchased DME is a covered expense if:

1. The manufacturer’s warranty is expired; and

2. The replacement cost is less than the repair cost; and

3. The replacement is not due to lost or stolen equipment or misuse or abuse of the equipment; or

4. Replacement is required due to a change in condition that makes the current equipment non-functional.
Duplicate DME is not covered.

**Prosthetics**

Initial prosthetic devices or supplies, including but not limited to, limbs and eyes are payable as shown on the Schedule of Benefits. Coverage will be provided for prosthetic devices necessary to restore minimal basic function. Replacement is a covered expense if due to pathological changes or growth. Repair of the basic prosthetic device, including replacing a part or putting together what is broken, is a covered expense.

**SPECIALTY DRUG MEDICAL BENEFIT**

Specialty drugs are payable as shown on the Schedule of Benefits.

For more information regarding specialty drugs, call the toll-free customer service telephone number on your ID card or log-in or register at www.humana.com. Once you have logged in to www.humana.com, under “Coverage and Claims”, “Viewing”, select your Prescription Drug Plan and click “Go”. Under “Related links”, click “Printable drug list and forms”. Select the Drug List and the specialty drugs will be indicated within that list.

**AMBULANCE**

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

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

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

2. Between hospitals; and

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

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

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

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

Air ambulance services are covered when medically necessary and the attending physician, or the Plan determines an air ambulance is the only medically appropriate means of transportation to the nearest appropriate facility.
Benefits are limited to services involving admissions for inpatients or treatment of an outpatient for emergency care.

**MORBID OBESITY**

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

**OBESITY**

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

**TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ)**

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

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

1. Diagnostic examination;
2. Diagnostic x-rays;
3. Injection of muscle relaxants;
4. Therapeutic drug injections;
5. Physical therapy;
6. Diathermy therapy;
7. Ultrasound therapy;
8. Splint therapy; and
Benefits are not provided for anything not listed above, including but not limited to:

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

**DENTAL INJURY**

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

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

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

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

**THERAPY SERVICES**

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

**Chiropractic Care**

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

**TRANSPLANT SERVICES**

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

**Covered Organ Transplant**

Only the *services*, care and treatment received for, or in connection with, the pre-approved transplant of the organs identified hereafter, which are determined by Humana to be *medically necessary services* and which are not *experimental, investigational or for research purposes* will be covered by this *Plan*. The transplant includes: pre-transplant *services*, transplant inclusive of any chemotherapy and associated *services*, post-discharge *services* and treatment of complications after transplantation of the following organs or procedures only:
1. Heart;
2. Lung(s);
3. Liver;
4. Kidney;
5. Bone Marrow*;
6. Intestine;
7. Pancreas;
8. Auto islet cell;
9. Multivisceral;
10. Any combination of the above listed organs;
11. Any organ not listed above required by federal law.

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

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

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

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

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

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

Covered Services

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

1. Hospital and qualified practitioner services, payable as shown on the Schedule of Benefits. If services are rendered at a Humana National Transplant Network (NTN) facility, covered expenses are paid in accordance to the NTN contracted rates;
2. Organ acquisition and donor costs. Except for bone marrow transplants, donor costs are not payable under this Plan if they are payable in whole or in part by any other group plan, insurance company, organization or person other than the donor's family or estate. Coverage for bone marrow transplants procedures will include costs associated with the donor-patient to the same extent and limitations associated with the covered person;
3. Direct, non-medical costs for the covered person will be paid as shown on the Schedule of Benefits, for: (a) transportation to and from the hospital where the transplant is performed; and (b) temporary lodging at a prearranged location when requested by the hospital and approved by Humana. These direct, non-medical costs are only available if the covered person lives more than 100 miles from the transplant facility;
4. Direct, non-medical costs for one support person of the covered person (two persons if the patient is under age 18 years) will be paid as shown on the Schedule of Benefits, for: (a) transportation to and from the approved facility where the transplant is performed; and (b) temporary lodging at a prearranged location during the covered person's confinement in the hospital. These direct, non-medical costs are only available if the covered person's support person(s) live more than 100 miles from the transplant facility.

BEHAVIORAL HEALTH SERVICES

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

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

Inpatient Services

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

Outpatient Services

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

Autism Services

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

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

Autism benefits are for rehabilitative, therapeutic and respite care services. Rehabilitative and therapeutic services are subject to review for medical necessity up to the benefit limit. This benefit shall not apply to other health or mental health conditions which are not related to the treatment of autism. Respite care has a separate monthly benefit allowance of $375.
Kentucky Employee Assistance Program (KEAP)

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

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

Limitations

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

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

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

OTHER COVERED EXPENSES

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

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

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

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

4. Reconstructive services following a covered mastectomy, including but not limited to:
   a. Reconstruction of the breast on which the mastectomy was performed;
   b. Reconstruction of the other breast to achieve symmetry;
   c. Prosthesis; and
   d. Treatment of physical complications of all stages of the mastectomy, including lymphedemas;
5. **Telehealth Consultation services.** Covered services include a medical or health consultation for purposes of patient diagnosis or treatment that requires the use of advanced telecommunications technology, including, but not limited to: (a) compressed digital interactive video, audio, or data transmission; and (b) clinical data transmission via computer imaging for teleradiology or telepathology; and (c) other technology that facilitates access to other covered health care services or medical specialty expertise;

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

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

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

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

9. Cochlear implants;

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

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

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

This Plan does not provide benefits for:

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

2. Immunizations required for foreign travel;

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

4. **Services** related to gender change;

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

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

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

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

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

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

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

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

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

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

g. Communication devices, except after surgical removal of the larynx or a diagnosis of permanent lack of function of the larynx;

h. Durable medical equipment, prosthesis, or orthotic device having convenience or luxury features which are not medically necessary, except that benefits for the cost of standard equipment or device used in the treatment of disease, sickness, or injury will be provided toward the cost of any deluxe equipment, prosthetic or device selected;

i. Vehicle adjustments, stair-gliders, emergency alert equipment, handrails, heat appliances.

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

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

16. Services that are not medically necessary, except routine/preventive services;

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

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

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

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

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

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

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

24. Any expense incurred for services received outside of the United States, except for emergency care services, unless otherwise determined by this Plan;
25. Treatment of nicotine habit or addiction, including, but not limited to hypnosis, smoking cessation products (except as covered and provided through the Pharmacy Benefit Manager), classes or tapes, unless otherwise determined by this Plan;

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

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

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

29. Off-evidence drug indications;

30. Over-the-counter medical items or supplies that can be provided or prescribed by a qualified practitioner but are also available without a written order or prescription, except for preventive services (with a prescription from a qualified practitioner);

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

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

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

34. Services that are billed incorrectly or billed separately, but are an integral part of another billed service;
35. Expenses for health clubs or health spas, aerobic and strength conditioning, work-hardening programs or weight loss or similar programs, and all related material and product for these programs;

36. *Alternative medicine*;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

52. Surrogate parenting;

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

54. Routine vision examinations;

55. Routine vision refraction;

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

57. Vision therapy;

58. Routine hearing examinations;

59. Routine hearing testing or screening, other than the screening of a newborn in the hospital;
60. Hearing aids, the fitting or repair of hearing aids or advice on their care; implantable hearing devices, except for cochlear implants and auditory brain stem implants as determined by this Plan or unless specifically provided under this Plan;

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

62. Services for a reversal of sterilization;

63. Contraceptive pills and patches, abortifacients and spermicide (see the Prescription Drug Benefit for coverage);

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

65. Dental osteotomies;

66. Infertility counseling and treatment services;

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

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

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

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

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

72. Halfway-house services;

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

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

75. Services, supplies, or other care for educational or training procedures used in connection with speech except as otherwise defined in the therapy or hearing services section;
76. Services, supplies, or other care provided to an inpatient solely for cardiac rehabilitation. Services, supplies, or other care provided for non-human, artificial, or mechanical hearts or ventricular and/or atrial assist devices used as a heart replacement (when not otherwise provided in conjunction with a human organ transplant) and supportive services or devices in connection with such care. This exclusion includes services for implantation, removal, and complications;

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

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

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

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

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

82. Services, supplies, or other care not meeting a Plan’s plan delivery system rules;

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

84. Marriage counseling.

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

BENEFITS SUBJECT TO THIS PROVISION

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

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

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

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

EFFECT ON BENEFITS

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

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

ORDER OF BENEFIT DETERMINATION

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

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

If a plan other than this Plan does not include provision 3, then the gender rule (male pays primary) will be followed to determine which plan is primary.
4. In the case of dependent children covered under the plans of divorced or separated parents, the following rules apply:
   a. The plan of a parent who has custody will pay the benefits first;
   b. The plan of a step-parent who has custody will pay benefits next;
   c. The plan of a parent who does not have custody will pay benefits next;
   d. The plan of a step-parent who does not have custody will pay benefits next.

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

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

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

**COORDINATION OF BENEFITS WITH MEDICARE**

**TRICARE AS SECONDARY PAYER**

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

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

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

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

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

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

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

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

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

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

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

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

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

CALCULATION AND PAYMENT OF BENEFITS

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

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

RIGHT OF RECOVERY

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

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

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

This Plan alone will determine against whom this right of recovery will be exercised.
SUBMITTING A CLAIM

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

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

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

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

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

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

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

Mail medical claims and correspondence to:

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

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

PROCEDURAL DEFECTS

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

ASSIGNMENTS AND REPRESENTATIVES

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

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

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

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

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

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

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

Pre-Service Claims

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

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

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

Urgent Care Claims

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

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

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

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

- Humana will notify the claimant of this Plan’s urgent care claim determination as soon as possible, but in no event more than 48 hours after the earlier of:
  1. This Plan's receipt of the specified information; or
  2. The end of the period afforded the claimant to provide the specified additional information.
Concurrent Care Decisions

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

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

Post-Service Claims

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

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

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

TIMES FOR DECISIONS

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

PAYMENT OF CLAIMS

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

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

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

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

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

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

NOTICES – GENERAL INFORMATION

A notice of an adverse benefit determination or final internal adverse benefit determination will include information that sufficiently identifies the claim involved, including:

1. The date of service;
2. The health care provider;
3. The claim amount, if applicable;
4. The reason(s) for the adverse benefit determination or final internal adverse benefit determination to include the denial code (e.g. CARC) and its corresponding meaning as well as a description of this Plan’s standard (if any) that was used in denying the claim. For a final internal adverse benefit determination, this description must include a discussion of the decision;
5. A description of available internal appeals and external review processes, including information on how to initiate an appeal; and
6. Disclosure of the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist individuals with internal claims and appeals, and external review processes.

The claimant may request the diagnosis code(s) (e.g. ICD-9) and/or the treatment code(s) (e.g. CPT) that apply to the claim involved with the adverse benefit determination or final internal adverse benefit determination notice. A request for this information, in itself, will not be considered a request for an appeal or external review.
INITIAL DENIAL NOTICES

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

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

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

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

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

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

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

APPEALS / GRIEVANCES

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

APPEALS OF ADVERSE BENEFIT DETERMINATIONS

A claimant must appeal an adverse benefit determination within 180 days after receiving written notice of the denial (or partial denial). With the exception of urgent care claims and concurrent care decisions, this Plan uses a two level appeals process for all adverse benefit determinations. Humana will make the determination on the first level of appeal. If the claimant is dissatisfied with the decision on this first level of appeal, or if Humana fails to make a decision within the time frame indicated below, the claimant may appeal to the Plan Administrator. Urgent care claims and concurrent care decisions (expedited internal appeals) are subject to a single level appeal process only, with Humana making the determination.
A first level and second level appeal must be made by a claimant by means of written application, in person, or by mail (postage prepaid), addressed to:

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

Appeals of denied claims will be conducted promptly, will not defer to the initial determination, and will not be made by the person who made the initial adverse claim determination or a subordinate of that person. The determination will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim.

A claimant may review relevant documents and may submit issues and comments in writing. A claimant on appeal may, upon request, discover the identity of medical or vocational experts whose advice was obtained on behalf of this Plan in connection with the adverse benefit determination being appealed, as permitted under applicable law.

If the claims denial being appealed is based in whole, or in part, upon a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or for research purposes, or not medically necessary or appropriate, the person deciding the appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The consulting health care professional will not be the same person who decided the initial appeal or a subordinate of that person.

**Time Periods for Decisions on Appeal -- First Level**

Appeals of claims denials will be decided and notice of the decision provided as follows:

<table>
<thead>
<tr>
<th>Urgent Care Claims</th>
<th>As soon as possible, but not later than 72 hours after Humana receives the appeal request. If oral notification is given, written notification will follow in hard copy or electronic format within the next 3 days.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Service Claims</td>
<td>Within a reasonable period, but not later than 15 days after Humana receives the appeal request.</td>
</tr>
<tr>
<td>Post-Service Claims</td>
<td>Within a reasonable period, but no later than 30 days after Humana receives the appeal request.</td>
</tr>
<tr>
<td>Concurrent Care Decisions</td>
<td>Within the time periods specified above, depending upon the type of claim involved.</td>
</tr>
</tbody>
</table>
Time Periods for Decisions on Appeal -- Second Level

Appeals of claims denials will be decided and notice of the decision provided as follows:

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Decision Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Service Claims</td>
<td>Within a reasonable period, but not later than 15 days after Humana receives the appeal request.</td>
</tr>
<tr>
<td>Post-Service Claims</td>
<td>Within a reasonable period, but no later than 30 days after Humana receives the appeal request.</td>
</tr>
</tbody>
</table>

APPEAL DENIAL NOTICES

Notice of a benefit determination on appeal will be provided to claimants by mail, postage prepaid, within the time frames noted above.

A notice that a claim appeal has been denied will convey the specific reason or reasons for the adverse benefit determination and the specific Plan provisions on which the determination is based.

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

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

In the event of a denial of an appealed claim, the claimant on appeal will be entitled to receive, upon request and without charge, reasonable access to and copies of any document, record or other information:

1. Relied on in making the determination;
2. Submitted, considered or generated in the course of making the benefit determination;
3. That demonstrates compliance with the administrative processes and safeguards required with respect to such determinations;
4. That constitutes a statement of policy or guidance with respect to this Plan concerning the denied treatment, without regard to whether the statement was relied on.
FULL AND FAIR REVIEW

As part of providing an opportunity for a full and fair review, this Plan shall provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by this Plan (or at the direction of this Plan) in connection with the claim. Such evidence shall be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided to give the claimant a reasonable opportunity to respond prior to that date.

Before a final internal adverse benefit determination is made based on a new or additional rationale, this Plan shall provide the claimant, free of charge, with the rationale. The rationale shall be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided to give the claimant a reasonable opportunity to respond prior to that date.

RIGHT TO REQUIRE MEDICAL EXAMINATIONS

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

EXHAUSTION

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

A claimant may seek immediate external review of an adverse benefit determination if Humana fails to strictly adhere to the requirements for internal claims and appeals processes set forth by the federal regulations, unless the violation was: a) Minor; b) Non-prejudicial; c) Attributable to good cause or matters beyond the Plan’s control; d) In the context of an ongoing good-faith exchange of information; and e) Not reflective of a pattern or practice of non-compliance. The claimant is entitled, upon written request, to an explanation of the Plan’s basis for asserting that it meets the standard, so the claimant can make an informed judgment about whether to seek immediate external review. If the external reviewer or the court rejects the claimant’s request for immediate review on the basis that the Plan met this standard, the claimant has the right to resubmit and pursue the internal appeal of the claim.

LEGAL ACTIONS AND LIMITATIONS

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

A claimant may file a request for an external review with Humana at the address listed below, within 4 months after the date the claimant received an adverse benefit determination or final internal adverse benefit determination notice that involves a medical judgment (excluding those that involve only contractual or legal interpretation without any use of medical judgment, as determined by the external reviewer) or a rescission of coverage. If there is no corresponding date 4 months after the notice date, the request must be filed by the first day of the 5th month following receipt of the notice. If the last filing date falls on a Saturday, Sunday or federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday or federal holiday.

A request for an external review must be made by a claimant by means of written application, by mail (postage prepaid), addressed to:

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

Preliminary Review

Within 5 business days following receipt of a request for external review, Humana must complete a preliminary review of the request to determine the following:

1. If the claimant is, or was, covered under this Plan at the time the health care item or service was requested or provided;

2. If the adverse benefit determination or final internal adverse benefit determination relates to the claimant’s failure to meet this Plan’s eligibility requirements;

3. If the claimant has exhausted this Plan’s internal appeals process, when required; and

4. If the claimant has provided all the information and forms required to process an external review.

Within 1 business day after completion of the preliminary review, Humana must provide written notification to the claimant of the following:

1. If the request is complete but not eligible for external review. The notice must include the reason(s) for its ineligibility and contact information for the Department of Health and Human Services Health Insurance Assistance Team (HIAT), including this number: 1-888-393-2789.

2. If the request is not complete. The notice must describe the information or materials needed to make it complete, and Humana must allow the claimant to perfect the external review request within whichever of the following two options is later:
   a. The initial 4-month filing period; or
   b. The 48-hour period following receipt of the notification.
Referral to an Independent Review Organization (IRO)

Humana must assign an independent IRO that is accredited by URAC, or another nationally-recognized accreditation organization to conduct the external review. Humana must attempt to prevent bias by contracting with at least 3 IROs for assignments and rotate claims assignments among them, or incorporate some other independent method for IRO selection (such as random selection). The IRO may not be eligible for financial incentives based on the likelihood that the IRO will support the denial of benefits.

The contract between Humana and the IRO must provide for the following:

1. **The assigned IRO will use legal experts where appropriate to make coverage determinations.**

2. **The assigned IRO will timely provide the claimant with written notification of the request's eligibility and acceptance of the request for external review.** This written notice must inform the claimant that he/she may submit, in writing, additional information that the IRO must consider when conducting the external review to the IRO within 10 business days following the date the notice is received by the claimant. The IRO may accept and consider additional information submitted after 10 business days.

3. **Humana must provide the IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination within 5 business days after assigning the IRO.** Failure to timely provide this information must not delay the conduct of the external review - the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination if this Plan fails to timely provide this information. The IRO must notify the claimant and Humana within 1 business day of making the decision.

4. **If the IRO receives any information from the claimant, the IRO must forward it to Humana within 1 business day.** After receiving this information, Humana may reconsider its adverse benefit determination or final internal adverse benefit determination. If Humana reverses or changes its original determination, Humana must notify the claimant and the IRO, in writing, within 1 business day. The assigned IRO will then terminate the external review.

5. **The IRO will review all information and documents timely received.** In reaching a decision, the IRO will not be bound by any decisions or conclusions reached during Humana’s internal claims and appeals process. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following when reaching a determination:
   a. The claimant's medical records;
   b. The attending health care professional's recommendation;
   c. Reports from the appropriate health care professional(s) and other documents submitted by Humana, claimant, or claimant's treating provider;
   d. The terms of the claimant's plan to ensure the IRO's decision is not contrary, unless the terms are inconsistent with applicable law;
   e. Appropriate practice guidelines, including applicable evidence-based standards that may include practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;
   f. Any applicable clinical review criteria developed and used by this Plan, unless inconsistent with the terms of this Plan or with applicable law; and
g. The opinion of the IRO’s clinical reviewer(s) after considering the information described above to the extent the information or documents are available and the reviewer(s) consider them appropriate.

6. The assigned IRO must provide written notice of the final external review decision within 45 days after receiving the external review request to the claimant and Humana. The decision notice must contain the following:
   a. A general description of the reason an external review was requested, including information sufficient to identify the claim including:
      (1) The date(s) of service;
      (2) The health care provider;
      (3) The claim amount (if applicable); and
      (4) The reason for the previous denial.
   b. The date the IRO received assignment to conduct the external review and the date of the IRO decision;
   c. References to the evidence or documentation considered in reaching the decision, including the specific coverage provisions and evidence-based standards;
   d. A discussion of the principal reason(s) for its decision, including the rationale and any evidence-based standards relied on in making the decision;
   e. A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either Humana or the claimant;
   f. A statement that judicial review may be available to the claimant; and
   g. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PPACA (section 2793 of PHSA, as amended).

7. After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for 6 years. An IRO must make such records available for examination by the claimant, Humana, or state/federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

Reversal of this Plan’s Decision

If Humana receives notice of a final external review decision that reverses the adverse benefit determination or final internal adverse benefit determination, it must immediately provide coverage or payment for the affected claim(s). This includes authorizing or paying benefits.

EXPEDITED EXTERNAL REVIEW

Request for an Expedited External Review

Expeditied external reviews are subject to a single level appeal process only.

Humana must allow a claimant to make a request for an expedited external review at the time the claimant receives:

1. An adverse benefit determination involving a medical condition of the claimant for which the time frame for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize the life or health of the claimant, or would jeopardize the claimant’s ability to regain maximum function and the claimant has filed a request for an expedited external review; or
2. A final internal adverse benefit determination involving a medical condition where:
   a. The time frame for completion of a standard external review would seriously jeopardize the life or health of the claimant, or would jeopardize the claimant's ability to regain maximum function; or
   b. The final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not be discharged from the facility.

A request for an expedited external review must be made by a claimant by means of written application, by mail (postage prepaid), addressed to:

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

Preliminary Review

Humana must determine whether the request meets the reviewability requirements for a standard external review immediately upon receiving the request for an expedited external review. Humana must immediately send a notice of its eligibility determination regarding the external review request that meets the requirements under the Standard External Review, Preliminary Review section.

Referral to an Independent Review Organization (IRO)

If Humana determines that the request is eligible for external review, Humana will assign an IRO as required under the Standard External Review, Referral to an Independent Review Organization (IRO) section. Humana must provide or transmit all necessary documents and information considered when making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically, by telephone/fax, or any other expeditious method.

The assigned IRO, to the extent the information is available and the IRO considers it appropriate, must consider the information or documents as outlined for the procedures for standard external review described in the Standard External Review, Referral to an Independent Review Organization (IRO) section. The assigned IRO is not bound by any decisions or conclusions reached during this Plan's internal claims and appeals process when reaching its decision.

Notice of Final External Review Decision

The IRO must provide notice of the final external review decision as expeditiously as the claimant's medical condition or circumstances require, but no more than 72 hours after the IRO receives the request for an expedited external review, following the notice requirements outlined in the Standard External Review, Referral to an Independent Review Organization (IRO) section. If the notice is not in writing, written confirmation of the decision must be provided within 48 hours to the claimant and Humana.
IF YOU HAVE QUESTIONS

For more information on your internal claims and appeals and external review rights, you can contact the Department of Health and Human Services Health Insurance Assistance Team (HIAT) at 1-888-393-2789.

STATE CONSUMER ASSISTANCE OR OMBUDSMAN TO ASSIST YOU WITH INTERNAL CLAIMS AND APPEALS AND EXTERNAL REVIEW PROCESSES

A state office of consumer assistance or ombudsman is available to assist you with internal claims and appeals and external review processes. The contact information is as follows:

Kentucky Department of Insurance, Consumer Protection Division
P.O. Box 517
Frankfort, KY 40602
(877)-587-7222
http://healthinsurancehelp.ky.gov
DOL.CAPOmbudsman@ky.gov
SECTION 3

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE
OPEN ENROLLMENT

Once annually you will have a choice of enrolling yourself and your eligible dependents in this Plan. You will be notified in advance when the Open Enrollment Period is to begin and how long it will last. If you initially declined coverage for yourself or your dependents at the time you were initially eligible for coverage, you will be able to enroll yourself and/or your eligible dependents during the Open Enrollment Period.

EMPLOYEE ELIGIBILITY

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

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

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

EMPLOYEE EFFECTIVE DATE OF COVERAGE

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

1. If your completed enrollment forms are signed by you within 35 days after your hire date, your coverage is effective on the 1st day of the 2nd month following the month of hire. Your coverage may be effective at a later date as determined by the Plan Sponsor (Commonwealth of Kentucky).
2. If your completed enrollment forms are signed by you more than 35 days after your hire date, you are a late applicant and you will not be eligible for coverage under this Plan until the next annual Open Enrollment Period or until you experience a permitted qualifying event. Your coverage is effective as determined by the Plan Sponsor (Commonwealth of Kentucky).

DEPENDENT ELIGIBILITY

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

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

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

Each dependent is eligible for coverage on:

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

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

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

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

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

**DEPENDENT EFFECTIVE DATE OF COVERAGE**

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

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

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

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

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

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

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

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

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

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

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

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

FAMILY CROSS-REFERENCE PAYMENT OPTION

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

- you must cover at least one dependent;
- the members must be legally married (husband and wife);
- the members must be eligible employees or retirees* of a group participating in the Kentucky Employees’ Health Plan;
- the members must elect the same coverage; and
- both members must sign the appropriate documentation during the enrollment process and file with their agency’s Insurance Coordinators.

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

* Members of the Judicial and Legislators Retirement Plans are not eligible to elect the cross-reference payment option.
TERMINATING THE FAMILY CROSS-REFERENCE PAYMENT OPTION

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

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

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

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

MEDICAL CHILD SUPPORT ORDERS

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

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

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

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

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

TERMINATING EMPLOYMENT

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

REINSTATMENT OF COVERAGE

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

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

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

FAMILY AND MEDICAL LEAVE ACT (FMLA)

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

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

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

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

RETIREE COVERAGE

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

SURVIVORSHIP COVERAGE

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

SPECIAL ENROLLMENT

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

1. Loss of coverage due to any of the following:
   a. Legal separation or annulment;
   b. Divorce;
   c. Cessation of dependent status (such as attaining the limiting age);
   d. Death;
   e. Termination of employment;
   f. Reduction in the number of hours of employment;
   g. Meeting or exceeding a lifetime limit on all benefits;
   h. Plan no longer offering benefits to a class of similarly situated individuals, which includes the employee;
   i. Any loss of coverage after a period that is measured by reference to any of the foregoing.
However, loss of coverage does not include a loss due to failure of the individual or the participant to pay *premiums* on a timely basis or termination of coverage for cause (such as making a fraudulent *claim* or an intentional misrepresentation of a material fact in connection with the plan).

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

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

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

1. Marriage;

2. Birth;

3. Adoption or placement for adoption;

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

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

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

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

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

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

*Please see your employer* for more details.
COVERAGE TERMINATION DUE TO PLAN CHANGE

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

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

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

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

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

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

Coverage may be elected under this Plan provided enrollment is within 35 days from the entitlement of Medicare.
Coverage terminates on the earliest of the following:

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

If you or any of your covered dependents no longer meet the eligibility requirements, you and your employer are responsible for notifying your Insurance Coordinator of the change in status. Coverage will not continue beyond the end of the month in which eligibility ends even if notice has not been given to Humana, employer, or Plan Sponsor (Commonwealth of Kentucky).
SECTION 4
GENERAL PROVISIONS AND REIMBURSEMENT/SUBROGATION
GENERAL PROVISIONS

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

PLAN ADMINISTRATION

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

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

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

RESCISSION

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

CONTESTABILITY

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

RIGHT TO REQUEST OVERPAYMENTS

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

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

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

TIME LIMIT ON CERTAIN DEFENSES

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

WORKERS' COMPENSATION NOT AFFECTED

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

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

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

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

MEDICAID

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

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

CONSTRUCTION OF PLAN TERMS

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

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

SUBROGATION

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

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

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

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

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

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

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

PLAN’S RIGHT TO ASSERT CLAIMS ON YOUR BEHALF

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

MISCELLANEOUS SUBROGATION

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

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

RETENTION OF AN ATTORNEY

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

PARTICIPANT’S NONCOMPLIANCE

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

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

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

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

REIMBURSEMENT/SUBROGATION EXCLUSIONS

Any covered expenses to the extent of any amount received from others for the bodily injuries or losses which necessitate such benefits. Without limitation, "amounts received from others" specifically includes, but is not limited to, liability insurance, worker's compensation, uninsured motorists, underinsured motorists, "no-fault" and automobile med-pay payments or recovery from any identifiable fund regardless of whether the beneficiary was made whole.
SECTION 5

NOTICES
IMPORTANT NOTICES FOR EMPLOYEES AND SPOUSES AGE 65 AND OVER

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

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

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

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

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

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

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

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

If you have any questions about how coverage under this Plan relates to Medicare coverage, please contact your Medicare office.
This Plan is required by law to maintain the privacy of your protected health information in all forms including written, oral and electronically maintained, stored and transmitted information and to provide individuals with notice of this Plan's legal duties and privacy practices with respect to protected health information.

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

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

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

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

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

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

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

Individuals who have access to protected health information in connection with their performance of Plan-related functions under the auspices of the Plan Administrator will be trained in these privacy policies and relevant procedures prior to being granted any access to protected health information. Humana and other Plan service providers will be required to safeguard protected health information against improper disclosure through contractual arrangements.
In addition, you should know that the employer/Plan Sponsor (Commonwealth of Kentucky) may legally have access, on an as-needed basis, to limited health information for the purpose of determining Plan costs, contributions, Plan design, and whether Plan modifications are warranted. In addition, federal regulators such as the Department of Health and Human Services and the Department of Labor may legally require access to protected health information to police federal legal requirements about privacy.

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

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

Please see the Kentucky Employees’ Health Plan Notice of Privacy Practices and HIPAA Privacy and Security Policies for additional information.
CONTINUATION OF MEDICAL BENEFITS

THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1986 (COBRA)

CONTINUATION OF BENEFITS

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

ELIGIBILITY

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

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

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

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

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

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

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

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

LOSS OF COVERAGE

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

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

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

NOTICES AND ELECTION

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

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

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

Under the law, continuation coverage must be elected within 60 days after Plan coverage ends, or if later, 60 days after the date of the notice of the right to elect continuation coverage. If continuation coverage is not elected within the 60 day period, the right to elect coverage under this Plan will end.
A covered employee or the spouse of the covered employee may elect continuation coverage for all covered dependents, even if the covered employee or spouse of the covered employee or all covered dependents are covered under another group health plan (as an employee or otherwise) prior to the election. The covered employee, his or her spouse and dependent child, however, each have an independent right to elect continuation coverage. Thus a spouse or dependent child may elect continuation coverage even if the covered employee does not elect it.

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

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

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

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

**MAXIMUM COVERAGE PERIOD**

Coverage may continue up to:

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

DISABILITY

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

SECOND QUALIFYING EVENT

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

TERMINATION BEFORE THE END OF MAXIMUM COVERAGE PERIOD

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

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

NOTE: The federal Health Insurance Portability and Accountability Act of 1996 requires portability of health care coverage effective for plan years beginning after June 30, 1997, an exclusion or limitation under the other group health plan may not apply at all to the qualified beneficiary, depending on the length of his or her prior creditable coverage.
TYPE OF COVERAGE; PREMIUM PAYMENT

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

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

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

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

OTHER INFORMATION

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

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

PLAN CONTACT INFORMATION

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

Notice about your Health Insurance Protections Under the Uniformed Services Employment and Reemployment Rights Act (USERRA)

The Uniformed Services Employment and Reemployment Right Act (USERRA) protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

Health Insurance Protection

- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.

- Even if you don’t elect to continue coverage during your military service, you have the right to be reinstated in your employer’s health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

USERRA affords other rights and protections including reemployment rights and the right to be free from discrimination and retaliation. To view the complete notice of your rights under USERRA, go to http://www.dol.gov/vets/programs/userra/USERRA_Private.pdf.
If your medical coverage under the Plan terminates, medical conversion coverage is available without medical examination. The medical conversion coverage will provide lesser benefits than this Plan.

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

1. Your coverage ends because your employment terminated;

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

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

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

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

LIMITATIONS

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

DUPLICATION OF COVERAGE

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the 2014 plans offered through the Kentucky Employees’ Health Plan. Therefore, the following deductibles and coinsurance apply:

If you would like more information on WHCRA benefits, contact the Kentucky Employees’ Health Plan at 888-581-8834 or 502-564-6534.

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).

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)

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

Premium Assistance under Medicaid and the Children’s Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

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

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

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2013. You should contact your State for further information on eligibility –

<table>
<thead>
<tr>
<th>ALABAMA – Medicaid</th>
<th>COLORADO – Medicaid and CHIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone: 1-855-692-5447</td>
<td>Medicaid Phone (In state): 1-800-866-3513</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ALASKA – Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Website: <a href="http://health.hss.state.ak.us/dpa/programs/medicaid/">http://health.hss.state.ak.us/dpa/programs/medicaid/</a></td>
</tr>
<tr>
<td>Phone (Outside of Anchorage): 1-888-318-8890</td>
</tr>
<tr>
<td>Phone (Anchorage): 907-269-6529</td>
</tr>
<tr>
<td>State</td>
</tr>
<tr>
<td>-----------------------</td>
</tr>
<tr>
<td>Arizona – CHIP</td>
</tr>
<tr>
<td>Florida – Medicaid</td>
</tr>
<tr>
<td>Georgia – Medicaid</td>
</tr>
<tr>
<td>Idaho – Medicaid and CHIP</td>
</tr>
<tr>
<td>Montana – Medicaid</td>
</tr>
<tr>
<td>Indiana – Medicaid</td>
</tr>
<tr>
<td>Iowa – Medicaid</td>
</tr>
<tr>
<td>Kansas – Medicaid</td>
</tr>
<tr>
<td>Kentucky – Medicaid</td>
</tr>
<tr>
<td>LOUISIANA – Medicaid</td>
</tr>
<tr>
<td>----------------------</td>
</tr>
<tr>
<td>Website: <a href="http://www.lahipp.dhh.louisiana.gov">http://www.lahipp.dhh.louisiana.gov</a></td>
</tr>
<tr>
<td>Phone: 1-888-695-2447</td>
</tr>
<tr>
<td><strong>MAINE</strong> – Medicaid</td>
</tr>
<tr>
<td>Website: <a href="http://www.maine.gov/dhhs/ofi/public-assistance/index.html">http://www.maine.gov/dhhs/ofi/public-assistance/index.html</a></td>
</tr>
<tr>
<td>Phone: 1-800-977-6740</td>
</tr>
<tr>
<td>TTY 1-800-977-6741</td>
</tr>
<tr>
<td><strong>MASSACHUSETTS</strong> – Medicaid and CHIP</td>
</tr>
<tr>
<td>Website: <a href="http://www.mass.gov/MassHealth">http://www.mass.gov/MassHealth</a></td>
</tr>
<tr>
<td>Phone: 1-800-462-1120</td>
</tr>
<tr>
<td><strong>MINNESOTA</strong> – Medicaid</td>
</tr>
<tr>
<td>Website: <a href="http://www.dhs.state.mn.us/">http://www.dhs.state.mn.us/</a></td>
</tr>
<tr>
<td>Click on Health Care, then Medical Assistance</td>
</tr>
<tr>
<td>Phone: 1-800-657-3629</td>
</tr>
<tr>
<td><strong>MISSOURI</strong> – Medicaid</td>
</tr>
<tr>
<td>Website: <a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a></td>
</tr>
<tr>
<td>Phone: 573-751-2005</td>
</tr>
<tr>
<td><strong>OKLAHOMA</strong> – Medicaid and CHIP</td>
</tr>
<tr>
<td>Website: <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a></td>
</tr>
<tr>
<td>Phone: 1-888-365-3742</td>
</tr>
<tr>
<td>State</td>
</tr>
<tr>
<td>---------------</td>
</tr>
<tr>
<td>PENNSYLVANIA</td>
</tr>
<tr>
<td>RHODE ISLAND</td>
</tr>
<tr>
<td>SOUTH CAROLINA</td>
</tr>
<tr>
<td>SOUTH DAKOTA</td>
</tr>
<tr>
<td>TEXAS</td>
</tr>
<tr>
<td>WASHINGTON</td>
</tr>
<tr>
<td>WEST VIRGINIA</td>
</tr>
<tr>
<td>WISCONSIN</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>State</th>
<th>Plan Type and CHIP</th>
<th>Website</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>VERMONT</td>
<td>Medicaid</td>
<td><a href="http://www.greenmountaincare.org/">http://www.greenmountaincare.org/</a></td>
<td>1-800-250-8427</td>
</tr>
<tr>
<td>VIRGINIA</td>
<td>Medicaid and CHIP</td>
<td><a href="http://www.dmas.virginia.gov/rcp-HIPP.htm">http://www.dmas.virginia.gov/rcp-HIPP.htm</a></td>
<td>1-800-432-5924</td>
</tr>
<tr>
<td>RHODE ISLAND</td>
<td>Medicaid</td>
<td><a href="http://www.dmas.virginia.gov/rcp-HIPP.htm">http://www.dmas.virginia.gov/rcp-HIPP.htm</a></td>
<td>1-800-432-5924</td>
</tr>
<tr>
<td>SOUTH CAROLINA</td>
<td>Medicaid</td>
<td><a href="http://www.dmas.virginia.gov/rcp-HIPP.htm">http://www.dmas.virginia.gov/rcp-HIPP.htm</a></td>
<td>1-800-432-5924</td>
</tr>
<tr>
<td>WISCONSIN</td>
<td>Medicaid</td>
<td><a href="http://www.dmas.virginia.gov/rcp-HIPP.htm">http://www.dmas.virginia.gov/rcp-HIPP.htm</a></td>
<td>1-800-432-5924</td>
</tr>
</tbody>
</table>
To see if any more States have added a premium assistance program since July 31, 2011, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor  U.S. Department of Health and Human Services
Employee Benefits Security Administration  Centers for Medicare & Medicaid Services
1-866-444-EBSA (3272)  1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 10/31/2016)
1. **Proper Name of Plan:** Kentucky Employees’ Health Plan

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

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

   **Common Name of Employer:** Commonwealth of Kentucky

4. **Plan Administrator and Named Fiduciary:**
   Commonwealth of Kentucky
   Personnel Cabinet, Department of Employee Insurance
   501 High Street
   Second Floor
   Frankfort, KY 40601

5. **Employer Identification Number:** 61-0600439

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

7. **Plan** benefits described in this booklet are effective January 1, 2014.

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

9. The fiscal year is July 1 through June 30 of each year.

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

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

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

    Humana Insurance Company
    500 West Main Street
    Louisville, KY 40202
    Telephone: Refer to your ID card
12. This is a self-insured health benefit plan. The cost of this Plan is paid with contributions shared by the employer and employee. Benefits under this Plan are provided from the general assets of the employer and are used to fund payment of covered claims under this Plan plus administrative expenses. Please see your employer for the method of calculating contributions and the funding mechanism used for the accumulation of assets through which benefits are provided under this Plan.

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

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

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

16. This Plan does not constitute a contract between the employer and any covered person and will not be considered as an inducement or condition of the employment of any employee. Nothing in this Plan will give any employee the right to be retained in the service of the employer, or for the employer to discharge any employee at any time.

17. This Plan is not in lieu of and does not affect any requirement for coverage by workers' compensation insurance.

18. This Plan is included in the Commonwealth of Kentucky Flexible Benefits Plan, a Cafeteria Plan created pursuant to the Internal Revenue Code Subsection 125.
SECTION 6
DEFINITIONS
DEFINITIONS

Italicized terms throughout this SPD have the meaning indicated below. Defined terms are italicized wherever found in this SPD.

A

**Accident** means a sudden event that results in a *bodily injury* and is exact as to time and place of occurrence.

**Admission** means entry into a facility as a registered bed patient according to the rules and regulations of that facility. An admission ends when you are discharged, or released, from the facility and you are no longer registered as a bed patient.

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

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

**Alternative medicine** means an approach to medical diagnosis, treatment or therapy that has been developed or practiced NOT using the generally accepted scientific methods in the United States of America. For purposes of this definition, alternative medicine shall include, but is not limited to: acupressure, aromatherapy, ayurveda, biofeedback, faith healing, guided mental imagery, herbal medicine, holistic medicine, homeopathy, hypnosis, macrobiotics, naturopathy, ozone therapy, reflexotherapy, relaxation response, rolfing, shiatsu and yoga.

**Ambulance** means a professionally operated vehicle, provided by a licensed ambulance service, equipped for the transportation of a sick or injured person to or from the nearest medical facility qualified to treat the person’s sickness or bodily injury. Use of the ambulance must be medically necessary and/or ordered by a qualified practitioner.

**Ambulatory surgical center** means an institution which meets all of the following requirements:

1. It must be staffed by physicians and a medical staff which includes registered nurses;
2. It must have permanent facilities and equipment for the primary purpose of performing surgery;
3. It must provide continuous physicians’ services on an *outpatient* basis;
4. It must admit and discharge patients from the facility within a 24-hour period;
5. It must be licensed in accordance with the laws of the jurisdiction where it is located. It must be operated as an *ambulatory surgical center* as defined by those laws;
6. It must not be used for the primary purpose of terminating pregnancies, or as an office or clinic for the private practice of any physician or dentist.

**Appeal** (or internal appeal) means review by this Plan of an adverse benefit determination.
Autism means a condition affecting a covered person ages one (1) through twenty-one (21) years of age, which includes:

(A) A total of six (6) or more items from subparagraphs 1, 2, and 3 of this paragraph, with at least two (2) from subparagraph 1 and one (1) each from subparagraphs 2 and 3:

1. Qualitative impairment in social interaction, as manifested by at least two (2) of the following:
   a. Marked impairment in the use of multiple nonverbal behavior such as eye-to-eye gaze, facial express, body postures, and gestures to regulate social interaction;
   b. Failure to develop peer relationships appropriate to developmental level;
   c. A lack of spontaneous seeking to share enjoyment, interests or achievement with other people; or
   d. Lack of social or emotional reciprocity.

2. Qualitative impairments in communications as manifested by at least one (1) of the following:
   a. Delay in, or total lack of, the development of spoken language;
   b. In individuals with adequate speech, marked impairment in the ability to imitate or sustain a conversation with others;
   c. Stereotyped and repetitive use of language or idiosyncratic language; or
   d. Lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental levels.

3. Restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one (1) of the following:
   a. Encompassing preoccupation with one (1) or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus;
   b. Apparently inflexible adherence to specific, nonfunctional routines or rituals;
   c. Stereotyped and repetitive motor mannerisms; or
   d. Persistent preoccupation with parts or objects.

(B) Delays or abnormal functioning in at least one (1) of the following areas, with onset prior to age three (3) years;

1. Social interaction;

2. Language as used in social communication; or

3. Symbolic or imaginative play; and

(C) The disturbance is not better accounted for by Rett’s Disorder or Childhood Disintegrative Disorder.

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

**Bariatric services** means the bariatric surgery and the post-discharge services and expenses related to complications following an approved bariatric surgery.

**Bariatric surgery** means gastrointestinal surgery to promote weight loss for the treatment of morbid obesity.

**Behavioral health** means mental health services and substance abuse services.

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

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

**Bodily injury** means bodily damage other than a sickness, including all related conditions and recurrent symptoms. However, bodily damage resulting from infection or muscle strain due to athletic or physical activity is considered a sickness and not a bodily injury.

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

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

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

**Childhood obesity**, for the purpose of this definition, means a child between the ages of 3 and 18 in the 85th percentile or greater of BMI for their age.

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

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

**COBRA Service Provider** means a provider of COBRA administrative services retained by Humana or the employer to provide specific COBRA administrative services.

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

1. Conditions whose diagnoses are distinct from pregnancy but adversely affected by pregnancy or caused by pregnancy. Such conditions include: acute nephritis, nephrosis, cardiac decompensation, hyperemesis gravidarum, puerperal infection, toxemia, eclampsia and missed abortion;

2. A non-elective cesarean section surgical procedure;

3. Terminated ectopic pregnancy; or

4. Spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.

**Complications of pregnancy** do not mean:

1. False labor;

2. Occasional spotting;

3. Prescribed rest during the period of pregnancy;

4. Conditions associated with the management of a difficult pregnancy but which do not constitute distinct complications of pregnancy; or

5. An elective cesarean section.

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

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

**Confinement** or **confined** means you are admitted as a registered bed patient in a hospital or a qualified treatment facility as the result of a qualified practitioner’s recommendation. It does not mean detainment in observation status.

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

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

**Copayment** means a specified amount the covered person must pay at the time services are rendered for certain covered services.
**Cosmetic surgery** means *surgery* performed to reshape structures of the body in order to change your appearance or improve self-esteem.

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

**Court-ordered** means involuntary placement in *behavioral health* treatment as a result of a judicial directive.

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

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

**Covered expense (or Covered services)** means *medically necessary services* incurred by you or your covered *dependents* for which benefits may be available under this *Plan*, subject to any *maximum benefit* and all other terms, provisions, limitations and exclusions of this *Plan*. A charge for a covered expense shall be considered to have been incurred on the date the service or supply was provided.

**Covered person** means the *member* (employee, retiree, COBRA participant) and his/her covered *dependents* enrolled for benefits provided under this *Plan*.

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

**Deductible** means a specified dollar amount of covered services that must be satisfied, either individually or combined as a covered family, per calendar year before this *Plan* pays benefits for certain specified services.

**Dental injury** means an injury to a sound natural tooth caused by a sudden, violent, and external force that could not be predicted in advance and could not be avoided.

**Dependent** means the following:

1. *Spouse* - a person of the opposite sex to whom you are legally married.

2. *Common Law Spouse* - a person of the opposite sex with whom you have established a Common Law union in a state which recognizes Common Law marriage (Kentucky does not recognize Common Law Marriage).

3. *Child Age 0 to 18* - in the case of a child who has not yet attained his/her 19th birthday, “child” means an individual who is:
   a. A son, daughter, stepson, or stepdaughter of the *employee*/*retiree*, or
   b. An eligible foster child of the *employee*/*retiree* (eligible foster child means an individual who is placed with the *employee*/*retiree* by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction), or
c. An adopted child of the employee/retiree (a legally adopted individual of the employee/retiree, or an individual who is lawfully placed with the employee/retiree for legal adoption by the employee/retiree, shall be treated as a child), or

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, or a adopted child as described above; and

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 dependent child will be considered totally and permanently disabled if, in the judgment of KEHP, the written certification adequately demonstrates that the Dependent child is unable to engage in any substantial gainful activity by reason of medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months.

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.
In general, a dependent under the KEHP for purposes of accident or health coverage is a dependent as defined 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”, this plan is not required to extend coverage to children who are eligible for coverage under another employer’s group health plan (e.g., eligible under the plan of the child’s own employer). This plan has interpreted this to mean the child full-time employer. A “grandfathered” plan cannot deny coverage if a child is eligible for coverage under another parent’s group health plan, however.

A “child” is an individual who is the employee’s son, daughter, stepson, or stepdaughter, and includes both a legally adopted individual of the employee and an individual lawfully placed with the employee for legal adoption by the employee. The term “child” also includes an eligible foster child, defined as a child placed with the employee by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

The definition change the age limit, residency, support, and other tests that would otherwise have to be met in order for an individual to qualify as a tax dependent under the Code do not apply to such an employee’s child for purposes of the tax-favored treatment of health coverage that is available under Code §§ 105(b) and 106.

The status as a “qualifying child” or “qualifying relative” under Section 152 will continue to be relevant when determining the tax treatment of health coverage for individuals who are 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.

**Diabetes equipment** means blood glucose monitors, including monitors designed to be used by blind individuals, insulin infusion pumps and associated accessories, insulin infusion devices and podiatric appliances for the prevention of complications associated with diabetes.

**Diabetes self-management training** means the training provided to a covered person after the initial diagnosis of diabetes for care and management of the condition including nutritional counseling and use of diabetes equipment and supplies. It also includes training when changes are required to the self-management regime and when new techniques and treatments are developed.

**Diabetes supplies** means test strips for blood glucose monitors, visual reading and urine test strips, lancets and lancet devices, insulin and insulin analogs, injection aids, syringes, prescriptive and non-prescriptive oral agents for controlling blood sugar levels, glucagon emergency kits and alcohol swabs.

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

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

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

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

**Eligible class** means performing on a regular, full-time basis all customary occupational duties, as determined by the employer, at the employer's business locations or when required to travel for the employer's business purposes. An employee shall be deemed at work on each day of a regular paid vacation and any regular non-working holiday.

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

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

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

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

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

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

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

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

**Enrollment date** means the first (1st) day of coverage of a member and his/her eligible dependents under the certificate, or, if there is a waiting period, the first day of the waiting period (typically the date employment begins).
Expense incurred means the fee charged for services provided to you. The date a service is provided is the expense incurred date.

Experimental, investigational or for research purposes:
Services, supplies, or other care, including treatments, procedures, hospitalizations, drugs, biological products or medical devices, which a Peer Review Panel determines are:
1. Not of proven benefit for the particular diagnosis or treatment of the covered person's particular condition;
2. Not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of the covered person's particular condition; or
3. Provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

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

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

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

2. Conclusive evidence from the published peer-review medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;
3. Demonstrated evidence as reflected in the published peer-review medical literature must exist that over time the technology leads to improvement in health outcomes, e.g., the beneficial effects outweigh any harmful effects;

4. Proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and

5. Proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph C, are possible in standard conditions of medical practice, outside clinical investigatory settings.

F

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

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

Freestanding renal dialysis facility means a provider other than a hospital which is primarily engaged in providing renal dialysis treatment, maintenance or training to outpatients.

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

Final external review decision means a determination by an independent review organization at the conclusion of an external review.

Final internal adverse benefit determination means an adverse benefit determination that has been upheld by this Plan at the completion of the internal appeals process (or an adverse benefit determination with respect to which the internal appeals process has been exhausted under the deemed exhaustion rules).

Functional impairment means a direct and measurable reduction in physical performance of an organ or body part.

H

Hazardous duty retiree means a retiree in (a) any position whose principal duties involve active law enforcement, including the positions of probation and parole officer and Commonwealth detective, active fire suppression or prevention, or other positions, including, but not limited to, pilots of the Transportation Cabinet and paramedics and Emergency Medical Technicians, with duties that require frequent exposure to a high degree of danger or peril and also require a high degree of physical conditioning, and (b) positions in the Department of Corrections in state correctional institutions and the Kentucky Correctional Psychiatric Center with duties that regularly and routinely require face-to-face contact with inmates.
Hearing aids means any wearable, non-disposable instrument or device designed to aid or compensate for impaired human hearing and any parts, attachments, or accessories, including ear molds, excluding batteries and cords. In addition, services necessary to assess, select, and appropriately adjust or fit the hearing aid to ensure optimal performance.

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

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

Hospital means an institution which:

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

Hospital does not include an institution which is principally a rest home, skilled nursing facility, convalescent home or home for the aged. Hospital does not include a place principally for the treatment of mental health or substance abuse.

Independent review organization (or IRO) means an entity that conducts independent external reviews of adverse benefit determinations and final internal adverse benefit determinations.

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

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

Intensive outpatient means outpatient services providing:

1. Group therapeutic sessions greater than one hour a day, three days a week;
2. Behavioral health therapeutic focus;
3. Group sessions centered on cognitive behavioral constructs, social/occupational/educational skills development and family interaction;
4. Additional emphasis on recovery strategies, monitoring of participation in 12-step programs and random drug screenings for the treatment of substance abuse; and
5. Qualified practitioner availability for medical and medication management.

Intensive outpatient program does not include services that are for:

1. Custodial care; or
2. Day care.

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

Late applicant means an employee and/or an employee’s eligible dependent who applies for medical coverage more than 35 days after the eligibility date. An individual shall not be considered a late enrollee if: (a) the person enrolls during his/her initial enrollment period; (b) the person enrolls during any annual open enrollment period; or (c) the person enrolls during a Special Enrollment period.
Maintenance care means any service or activity which seeks to prevent bodily injury or sickness, prolong life, promote health or prevent deterioration of a covered person who has reached the maximum level of improvement or whose condition is resolved or stable.

Maximum allowable fee for a covered expense is the lesser of:

1. The fee charged by the provider for the services;
2. The fee that has been negotiated with the provider whether directly or through one or more intermediaries or shared savings contracts for the services;
3. The fee established by this Plan by comparing rates from one or more regional or national databases or schedules for the same or similar services from a geographical area determined by this Plan;
4. The fee based upon rates negotiated by this Plan or other payors with one or more participating providers in a geographic area determined by this Plan for the same or similar services;
5. The fee based upon the provider’s cost for providing the same or similar services as reported by such provider in its most recent publicly available Medicare cost report submitted to the Centers for Medicare and Medicaid Services (CMS) annually; or
6. The fee based on a percentage determined by this Plan of the fee Medicare allows for the same or similar services provided in the same geographic area.

Note: The bill you receive for services from non-participating providers may be significantly higher than the maximum allowable fee. In addition to deductibles, copayments and coinsurance, you are responsible for the difference between the maximum allowable fee and the amount the provider bills you for the services. Any amount you pay to the provider in excess of the maximum allowable fee will not apply to your out-of-pocket limit or deductible.

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

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

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


**Medicare** means a program of medical insurance for the aged and disabled, as established under Title 18 of the Social Security Act of 1965, as amended.

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

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

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

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

**Morbid obesity** (clinically severe obesity) means a body mass index (BMI) as determined by a qualified practitioner as of the date of service of:

1. 40 kilograms or greater per meter squared (kg/m²); or

2. 35 kilograms or greater per meter squared (kg/m²) with an associated comorbid condition such as hypertension, type II diabetes, life-threatening cardiopulmonary conditions; or joint disease that is treatable, if not for the obesity.

**Non-participating (Non-PAR) provider** means a hospital, qualified treatment facility, qualified practitioner or any other health services provider who has not entered into an agreement with the Plan Manager (Humana) to provide participating provider services or has not been designated by the Plan Manager (Humana) as a participating provider.

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

**Off-evidence drug indications** mean indications for which there is a lack of sufficient evidence for safety and/or efficacy for a particular medication.
Off-label drug indications mean prescribing of an FDA-approved medication for a use or at a dose that is not included in the product indications or labeling. This term specifically refers to drugs or dosages used for diagnoses that are not approved by the FDA and may or may not have adequate medical evidence supporting safety and efficacy. Off-label prescribing of traditional drugs is a common clinical practice and many off-label uses are effective, well documented in peer reviewed literature and widely employed as standard of care treatments.

Orthotic means a fitted or custom-made brace, splint, cast, support or other device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body when prescribed by a qualified practitioner.

Out-of-pocket limit is a specified dollar amount that must be satisfied, either individually or combined as a covered family, per calendar year before a benefit percentage will be increased. Any deductible amount, all copayments under this medical SPD where applicable, will be included in the out-of-pocket maximum. When the out-of-pocket limit is reached, coinsurance ceases for those covered services specified in the schedule of benefits. It does not include any amounts not paid because a maximum benefit limit has been reached, or any amount above an eligible expense.

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

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

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

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

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

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

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

Participating (PAR) provider means a hospital, qualified treatment facility, qualified practitioner or any other health services provider who has entered into an agreement with, or has been designated by, Humana to provide specified services to all covered persons.
DEFINITIONS (continued)

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

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

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

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

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

Plan Administrator means Commonwealth of Kentucky.

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

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

Plan Sponsor means Commonwealth of Kentucky.

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

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

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

Precertification (also known as “preauthorization”) means the process of assessing the medical necessity, appropriateness, or utility of proposed non-emergency hospital admissions, surgical procedures, outpatient care, and other health care services.

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

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

Premium Due Date means the date on which a premium is due to maintain coverage under this certificate.
**Prescription** means a direct order for the preparation and use of a drug, medicine or medication. The drug, medicine or medication must be obtainable only by prescription. The prescription must be given to a pharmacist verbally, electronically or in writing by a qualified practitioner for the benefit of and use by a covered person. The prescription must include at least:

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

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

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

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

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

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

---

154
Psychiatric Facility means a provider primarily engaged in providing diagnostic and therapeutic services for the treatment of mental health conditions. The facility must be operated in accordance with the laws of the jurisdiction in which it is located and provide treatment by or under the care of physicians and nursing services whenever the patient is in the facility.

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

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

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

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

Registered Nurse First Assistant means a nurse who:

1. Holds a current active registered nurse licensure;

2. Is certified in perioperative nursing; and

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

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

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

1. Is licensed as a 24-hour residential facility for mental health and substance abuse treatment, although not licensed as a hospital;

2. Provides a multidisciplinary treatment plan in a controlled environment, with periodic supervision of a physician or a Ph.D. psychologist; and

3. Provides programs such as social, psychological and rehabilitative training, age appropriate for the special needs of the age group of patients, with focus on reintegration back into the community.

Residential treatment is utilized to provide structure, support and reinforcement of the treatment required to reverse the course of behavioral deterioration.

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

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

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

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

Single coverage means coverage for the member only.

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

Sound natural tooth means a tooth that:

1. Is organic and formed by the natural development of the body (not manufactured);

2. Has not been extensively restored;

3. Has not become extensively decayed or involved in periodontal disease; and

4. Is not more susceptible to injury than a whole natural tooth.
**Special enrollment period** means a period of time during which an eligible person or dependent who loses other health insurance coverage or incurs a change in status may enroll in the plan without being considered a late enrollee.

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

**Specialty drug** means a drug, medicine or medication used as a specialized therapy developed for chronic, complex sicknesses or bodily injuries. Specialty drugs may:

1. Require nursing services or special programs to support patient compliance;

2. Require disease-specific treatment programs;

3. Have limited distribution requirements; or

Have special handling, storage or shipping requirements.

**Substance abuse** means the abuse of, or psychological or physical dependence on, or addiction to alcohol or a controlled substance.

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

**Summary Plan Description (SPD)** means this document which outlines the benefits, provisions and limitations of this Plan.

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

**Telehealth services** mean- the use of interactive audio, video, or other electronic media to deliver health care. It includes the use of electronic media for diagnosis, consultation, treatment, transfer of medical data, and medical education. A telehealth consultation shall not be reimbursable if it is provided through the use of an audio-only telephone, facsimile machine, or electronic mail.
Therapy Service means services, supplies, or other care used for the treatment of a sickness or bodily injury to promote the recovery of the patient. Therapy services include, but are not limited to:

1. Physical Therapy – The treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, biomechanical and neurophysiological principles and devices to relieve pain, restore maximum function, and prevent disability following disease, bodily injury or loss of a body part.

2. Respiratory Therapy – Introduction of dry or moist gases into the lungs for treatment purposes.

3. Speech Therapy – The treatment rendered to gain speech loss due to sickness or bodily injury, or as a result of complications at birth, congenital anomaly, or previous medical treatment.

4. Cardiac Rehabilitation – Treatment provided to individuals who have suffered a heart attack, have had heart surgery, or have other cardiac problems.

5. Occupational Therapy – The treatment program of prescribed activities coordination and mastery, designed to assist a person to gain independence, particularly in the normal activities of daily living.

Timely applicant means an employee and/or an employee's eligible dependent who applies for medical coverage within 35 days of the eligibility date.

Total disability or totally disabled means:

1. During the first twelve months of disability you or your employed covered spouse are at all times prevented by bodily injury or sickness from performing each and every material duty of your respective job or occupation;

2. After the first twelve months, total disability or totally disabled means that you or your employed covered spouse are at all times prevented by bodily injury or sickness from engaging in any job or occupation for wage or profit for which you or your employed covered spouse are reasonably qualified by education, training or experience;

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

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

TRICARE is the name of the federal government’s managed health care program for active-duty military, active-duty service families, retirees and their families, and other beneficiaries. An individual who is ordered to active duty for more than 30 days is automatically enrolled in TRICARE (TRICARE Prime a HMO-type option) and the individual’s dependents are also eligible to receive benefits under TRICARE.

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

1. Could seriously jeopardize the life or health of the *claimant* or the ability of the *claimant* to regain maximum function; or

2. In the opinion of the physician with knowledge of the *claimant’s* medical condition, would subject the *claimant* to severe pain that cannot be adequately managed without the care or treatment recommended.

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

**W**

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

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

**Y**

**You and your** means *you* as the *employee* and any of *your* covered *dependents*, unless otherwise indicated.
SECTION 7

ADDITIONAL NOTICES
NOTICE TO ENROLLEES CONCERNING TOBACCO

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

Notice of Privacy Practices

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully!

Effective August 1, 2013

This Notice of Privacy Practices (the “Notice”) describes the legal obligations of the Kentucky Employees’ Health Plan (“KEHP” or “Plan”) and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and subsequent regulations. This Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice of Privacy Practices to you pursuant to HIPAA.
If you have any questions about this Notice or about our privacy practices, please contact: Sharron S. Burton, Deputy Executive Director and Privacy Officer, Office of Legal Services, Personnel Cabinet, 501 High Street, 3rd Floor, Frankfort, Kentucky 40601; Phone: (502) 564-7430; Fax: (502) 564-7603; E-mail: Sharron.Burton@ky.gov.

KEHP Responsibilities

We are required by law to:
- Maintain the privacy of your protected health information;
- Provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information;
- Notify affected individuals following a breach of unsecured protected health information; and
- Abide by the terms of the Notice that is currently in effect.
We reserve the right to change the terms of this Notice and to make new notice provisions effective regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will post the change or the revised Notice on the Personnel Cabinet, Department of Employee Insurance website at www.kehp.ky.gov. In addition, notice regarding our privacy practices will be included in the annual open enrollment materials.

What is Protected Health Information?

The HIPAA Privacy Rule protects only certain medical information known as protected health information. **Protected Health Information or PHI** is individually identifiable health information that is transmitted or maintained in electronic media or in any other form or medium. PHI does not include employment records held by an employer acting in their role of employer.

Individually identifiable health information is health information about you, including demographic information such as your name, address, telephone number, or Social Security number. It also includes information that is created or received by a health care provider, a health plan, and employer that relates to your physical or mental health or condition, the provision of health care to you, or the payment of your healthcare.

Permitted Use and Disclosures

Under the law, we may use or disclose your PHI under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your PHI. For each category of uses and disclosures, we will explain what we mean and provide examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the listed categories.

We have the right to use and disclose your PHI:

- **To You or Your Personal Representative** including corresponding with you about your plan and benefits available to you;
- Pursuant to and in compliance with a **Valid Authorization** or an **Agreement** with you;
- **For Treatment**, including the provision, coordination, or management of health care and related services;
- **For Payment**, including activities to collect premiums, to fulfill responsibility for coverage and provide benefits under the health plan, to obtain or provide reimbursement for the provision of health care, to determine eligibility or coverage, to process claims, to adjudicate or subrogate claims, to pay for the treatment and services you receive from health care providers, to carry out collection activities, and to perform utilization review activities such as preauthorization;
- **For Health Care Operations** including conducting quality assessment and improvement, engaging in activities to improve health or reduce health care costs, conducting case management and care coordination, contacting doctors and patients with information about treatment alternatives, reviewing the competence or qualifications of and credentialing health care providers, enrollment activities, premium rating, arranging for medical review and auditing functions, arranging for legal review, fraud and abuse detection programs, resolving internal grievances, providing customer service, business planning and development, and for general Plan administration activities;
- **Incident** to a use or disclosure otherwise permitted by HIPAA;
ADDITIONAL NOTICES (continued)

- **To Business Associates** that create, receive, maintain, or transmit PHI on behalf of KEHP. A Business Associate may provide legal, actuarial, accounting, consulting, data aggregation, management, and administrative services for KEHP. A Business Associate may only disclose your information as permitted or required by its contract with KEHP or as required by law;

- **To Plan Sponsors** including employees who require PHI for the administration of the Plan. These employees will only use or disclose that information necessary to perform Plan administration functions, such as enrollment and termination, or as otherwise required by HIPAA, unless you have authorized further disclosures;

- **An Employer** about an individual who is a member of the workforce of the employer if the PHI that is disclosed consists of findings concerning a work-related illness or injury or a workplace-related medical surveillance; and

- **As Required by Federal, State, or Local Law** and the use or disclosure complies with and is limited to the relevant requirements of such law.

To the extent required and permitted by law, when using or disclosing PHI, KEHP will make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.

**Limited Uses and Disclosures:**

We may, with certain limitations specified by HIPAA, use and disclose PHI about you:

- **To a Family Member, Relative, Close Personal Friend, Personal Representative or Any Other Person identified by you** provided the disclosure is directly relevant to such persons’ involvement with your health care or payment related to your health care;

- **To Notify** or assist in the notification of a family member, your personal representative, or another person responsible for your care regarding your location, general condition, or death;

- **To a Public or Private Entity** authorized by law or by its charter to assist in disaster relief efforts;

- **As Required by Federal, State, or Local Law** and the use or disclosure complies with and is limited to the relevant requirements of such law;

- **For Public Health Activities** including disclosure to a public health authority that is authorized by law to collect or receive PHI for the purpose of preventing or controlling disease, injury, or disability which includes reporting of disease, injury, or vital events such as birth or death, and the conduct of public health surveillance, public health investigations, and public health interventions; to report child abuse or neglect; to collect or report on the quality, safety, or effectiveness of products or activities; to enable product recalls, repairs, or replacements; to notify a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition;

- **To your Employer** if you receive health care at the request of your employer for the evaluation relating to medical surveillance of the workplace or to evaluate whether you have had a work-related illness or injury;

- **To a School** if you are a student or a prospective student of the school and the PHI that is disclosed is limited to proof of immunization, the school is required to have such proof, and you or a personal representative agree to the disclosure;
To a Government Authority if we reasonably believe that you are a victim of abuse, neglect, or domestic violence to the extent the disclosure is required by law, you agree to the disclosure, or the disclosure is expressly authorized by law and we believe the disclosure is necessary to prevent serious harm to you or other potential victims, or you are unable to agree because of incapacity;

To a Health Oversight Agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; or other activities necessary for appropriate oversight of the health care system, government benefit programs, government regulatory programs, and determining compliance with civil rights laws;

In the Course of any Judicial or Administrative Proceeding and in response to an order of a court or administrative tribunal, a subpoena, a discovery request, or other lawful process;

To Law Enforcement including instances where you are suspected to be a victim of a crime, or for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person;

To a Coroner or Medical Examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law;

To a Funeral Director as necessary to carry out their duties with respect to the decedent;

To Organ Procurement Organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue and for the purpose of facilitating organ, eye, or tissue donation or transplantation;

For Research Purposes when the individual identifiers have been removed or an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information and approves the research;

To Avert a Serious Threat to Health or Safety and the disclosure is to persons reasonably able to prevent or lessen the threat or is necessary for law enforcement authorities to identify or apprehend an individual;

For Military and Veterans Activities or to Federal Officials for purposes including to assure the proper execution of a military mission, conducting lawful intelligence and counter-intelligence, conducting national security activities, and providing protective services to the President;

To Correctional Institutions and other Law Enforcement Custodians about inmates;

To Government Agencies Administering a Government Program providing public benefits if the sharing of eligibility or enrollment information among such government agencies or the maintenance of such information in a single or combined data system accessible to all such government agencies is required or expressly authorized by statute or regulation;

For Workers’ Compensation compliance purposes or other similar programs that provide benefits for work-related injuries or illness without regard to fault; and
➢ To Raise Funds provided the use or disclosure is to a Business Associate or an institutionally-related foundation and the information used or disclosed is limited to that permitted by HIPAA. You have a right to opt out of receiving fundraising communications. See, the “Your Rights Under HIPAA” section of this Notice.

Required Uses and Disclosures:

We are required to disclose your PHI:

➢ To You upon request;

➢ To Your Personal Representative unless we have a reasonable belief that you may be subjected to domestic violence, abuse, or neglect or treating such person as the personal representative could endanger you, or we decide that it is not in the best interest of the individual to treat the person as your personal representative. We will require written notice/authorization and supporting documentation proving that an individual has been designated as your personal representative; and

➢ To the Secretary of the U.S. Department of Health & Human Services as directed when required to investigate or determine the Plan’s compliance with HIPAA.

Prohibited Uses and Disclosures:

We are prohibited from:

➢ Using or disclosing Genetic Information for underwriting purposes;

➢ Using or disclosing PHI in violation of a Restriction to which KEHP has agreed except where emergency treatment is needed;

➢ Except as indicated in the Permitted, Limited, and Required Uses and Disclosures sections of this Notice, using or disclosing PHI without a Valid Authorization including the use and disclosure of psychotherapy notes, the use and disclosure of information for marketing purposes, and the sale of PHI; and

➢ Disclosing PHI to a Plan sponsor for the purpose of Employment-Related Actions or Decisions or in connection with any other benefit or employee benefit plan of the Plan sponsor.

Uses and Disclosures that Require Authorization:

Except as otherwise described in this Notice, we may not use or disclose PHI without a valid authorization.

A valid authorization is specifically required:

➢ For any use or disclosure of Psychotherapy Notes, except to carry out treatment, payment, or health care operations or to defend KEHP in a legal action or other proceeding brought by you;

➢ For any use or disclosure of PHI for Marketing except if the communication is in the form of a face-to-face communication with you or a promotional gift of nominal value is provided. “Marketing” does not include communications made to describe a health-related product or service that is provided by, or included in the plan of benefits of KEHP; and
For any disclosure of protected health information which is a Sale of such information.

Uses and disclosures of PHI that are not described in this Notice will be made only with the individual’s written valid authorization.

A valid authorization must be written in plain language and include specific information. For your convenience, and to ensure that your authorization is valid and contains all required information, you may submit your authorization on KEHP’s “Authorization for Release of Your Protected Health Information” form. The form may be obtained by contacting the Privacy Officer or by accessing KEHP’s Web site at www.kehp.ky.gov.

You may revoke an authorization previously given at any time provided the revocation is in writing and:

- Except to the extent that KEHP has taken action in reliance on the authorization; or
- If the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Your Rights under HIPAA

You have the right to:

- **Request Restrictions** on certain uses and disclosures of PHI to carry out treatment, payment, or health care operations. You may also request restrictions on uses and disclosures of your PHI to family members, relatives, close personal friends, or other persons identified by you who are involved in your health care or payment for that care. We are not required to agree to your requested restriction except:
  - When the disclosure is for the purpose of carrying out payment or health care operations;
  - The disclosure is not otherwise required by law; and
  - The PHI pertains solely to a health care item or service for which the individual, or person other than the health plan on behalf of the individual, has paid in full.

Your request for a restriction must be made in writing and:

  - Identify the information you want to restrict;
  - State whether you want to limit our use, disclosure, or both; and
  - Identify the persons to whom you want the restriction to apply (i.e. your spouse).

If we agree to a requested restriction on certain uses and disclosures, we will not use or disclose PHI in violation of such restriction, except where the restricted information is needed to provide emergency treatment.

For your convenience, and to ensure that your request contains all necessary information, you may submit your request on KEHP’s “Request for Restriction on Use and Disclosure of Your Protected Health Information” form. The form may be obtained by contacting the Privacy Officer or by accessing KEHP’s Web site at www.kehp.ky.gov;
➢ **Receive Confidential Communications.** You may request to receive communications of PHI by alternative means or at alternative locations (i.e. at home, at work). Your request must be made in writing.

We will accommodate all reasonable requests provided:
- You state that the disclosure of all or part of your PHI could endanger you;
- You specify how payment, if any, will be handled; and
- You provide an alternate address or other method of contact.

For your convenience, and to ensure that your request contains all necessary information, you may submit your request on KEHP’s “Request for Alternative Communications Regarding Your Protected Health Information” form. The form may be obtained by contacting the Privacy Officer or by accessing KEHP’s Web site at [www.kehp.ky.gov](http://www.kehp.ky.gov);

➢ **Inspect and Copy** your PHI in a designated record set except for:

- Psychotherapy notes;
- Information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding;
- PHI that is subject to or exempt from the Clinical Laboratory Improvements Amendments of 1988;
- PHI not maintained in a designated record set;
- If access is temporarily suspended because research is in progress, provided you have agreed to the denial of access when consenting to participate in the research;
- If denial of access under the Privacy Act would meet the requirements of that law; and
- If your information was obtained from someone other than a health care provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information.

Your request for access to or a copy of your PHI must be made in writing and is subject to a reasonable, cost-based fee.

You have a right to a review of certain denials of access to your PHI by a licensed health care professional who was not directly involved in the denial.

For your convenience, and to ensure that your request contains all necessary information, you may submit your request on KEHP’s “Request to Inspect or Copy Your Protected Health Information” form. The form may be obtained by contacting the Privacy Officer or by accessing KEHP’s Web site at [www.kehp.ky.gov](http://www.kehp.ky.gov);

➢ **Amend** your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set. We may deny your request for amendment if we determine that the PHI or record that is the subject of the request:

- Was not created by us, unless you provide a reasonable basis to believe that the originator of the PHI is no longer available to act on the requested amendment;
- Is not part of the information that you would be permitted to inspect and copy;
- Would not be available for inspection due to an exception; or
- Is accurate and complete.
Your request for a restriction must be made in writing and include a reason to support the requested amendment.

You have a right to submit a written statement disagreeing with a denial to amend. If you do not submit a statement of disagreement, you may request that we provide your request for amendment and the denial with any future disclosures of the PHI that is the subject of the amendment.

For your convenience, and to ensure that your request contains all necessary information, you may submit your request on KEHP’s “Request to Amend Your Protected Health Information” form. The form may be obtained by contacting the Privacy Officer or by accessing KEHP’s Web site at www.kehp.ky.gov;

- **Receive an Accounting of Disclosures** of PHI made by us in the six years prior to the date on which the accounting is requested, except for uses and disclosures:
  - To carry out treatment, payment, and health care operations;
  - Made to you about your PHI;
  - Incident to a use or disclosure otherwise permitted or required by HIPAA;
  - Made pursuant to an authorization;
  - To persons involved in your care or other permitted notifications;
  - For national security or intelligence purposes;
  - To correctional institutions or law enforcement officials; or
  - Temporarily suspended by a health oversight agency or law enforcement official.

Your request for an accounting of disclosures must be made in writing and:
- State in what form you want the list (i.e. paper, electronic);
- State a time period of not longer than six years prior to the date of your request; and
- Is subject to a reasonable, cost-based fee.

For your convenience, and to ensure that your request contains all necessary information, you may submit your request on KEHP’s “Request for Accounting of Disclosures of Your Protected Health Information” form. The form may be obtained by contacting the Privacy Officer or by accessing KEHP’s Web site at www.kehp.ky.gov;

- **Receive a Paper Copy of this Notice** at any time upon request. Your request must be made in writing and submitted to the Privacy Officer. The Notice may be viewed at our Web site, www.kehp.ky.gov;

- **Be Notified of a Breach of Unsecured Protected Health Information.** Following the discovery of a breach of unsecured PHI we will notify you if your information has been or we reasonably believe your information has been accessed, acquired, used, or disclosed as a result of such breach; and

- **Complain** to us and to the Secretary of the U.S. Department of Health and Human Services ("HHS") if you believe your privacy rights have been violated. Your complaint must:
  - Be in writing;
  - Name the person that is the subject of the complaint;
  - Describe the acts or omissions believed to be in violation of HIPAA; and
  - Be filed within 180 days of when the complainant knew or should have known that the act or omission complained of occurred, unless this time limit is waived by the Secretary of HHS for good cause shown.

You will not be penalized or retaliated against for filing a complaint with us or with the Secretary.
All written requests and complaints must be submitted to:

ATTN: HIPAA Privacy Officer  
Commonwealth of Kentucky  
Personnel Cabinet  
Department of Employee Insurance  
502 High Street, 3rd Floor  
Frankfort, KY 40601

If you are submitting a complaint to the Secretary of HHS, you should follow the complaint filing instructions on the HHS website at [www.hhs.gov](http://www.hhs.gov).
Dependent eligibility rules and verification requirements are contained in the following chart. Dependent verification for Qualifying Events must be submitted with the Qualifying Event documents. Qualifying Event documents must be signed within the event timeframe.

<table>
<thead>
<tr>
<th>Definition of Eligible Dependent(s)</th>
<th>Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Spouse</strong></td>
<td>A legible photocopy of the marriage certificate or a legible photocopy of the top half of the front page of the employee/retiree's most recent federal tax return (Form 1040).</td>
</tr>
<tr>
<td>A person of the opposite sex who is legally married to an employee or retiree.</td>
<td></td>
</tr>
<tr>
<td><strong>Common Law Spouse</strong></td>
<td>A legible photocopy of the certificate of affidavit of common law marriage from a state that does recognize common law marriage.</td>
</tr>
<tr>
<td>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).</td>
<td></td>
</tr>
<tr>
<td><strong>Child Age 0 to 18</strong></td>
<td><strong>Natural Child</strong>: A legible photocopy of the child's birth certificate showing the name of the employee/retiree as a parent. <strong>Step Child</strong>: A legible photocopy of the child's birth certificate showing the name of the employee/retiree's Spouse as a parent; and a legible copy of the marriage certificate showing the names of the employee/retiree and the Spouse. <strong>Legal Guardian, Adoption, or Foster child(ren)</strong>: Legible photocopies of court orders, guardianship documents, affidavits of dependency, with the presiding judge's signature and filed status; or legible adoption or legal placement decrees with the presiding judge's signature.</td>
</tr>
<tr>
<td>In the case of a child who has not yet attained his/her 19th birthday, “child” means an individual who is –</td>
<td></td>
</tr>
<tr>
<td>• A son, daughter, stepson, or stepdaughter of the employee/retiree, or</td>
<td></td>
</tr>
<tr>
<td>• 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</td>
<td></td>
</tr>
<tr>
<td>• 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) or</td>
<td></td>
</tr>
<tr>
<td><strong>Child Age 19 to 25</strong></td>
<td>Must submit the documents described above for children.</td>
</tr>
<tr>
<td>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 –</td>
<td></td>
</tr>
<tr>
<td>• A son, daughter, stepson, stepdaughter, eligible foster child, an adopted child as described above; AND</td>
<td></td>
</tr>
<tr>
<td>• <strong>NOT</strong> eligible to enroll in an employer-sponsored health plan offered by the child’s full-time employer.</td>
<td></td>
</tr>
<tr>
<td><strong>Disabled Dependent</strong></td>
<td><strong>Contact the Enrollment Information Branch at 502-564-1205 for the specific documentation needed.</strong></td>
</tr>
<tr>
<td>------------------------</td>
<td>-----------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>A dependent child who is totally and permanently disabled may be covered by KEHP 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 dependent child will be considered totally and permanently disabled if, in the judgment of KEHP, the written certification adequately demonstrates that the dependent child is unable to engage in any substantial gainful activity by reason of medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months.</td>
<td></td>
</tr>
</tbody>
</table>
Grievance Process for Eligibility and Enrollment Issues

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

Grievances must be filed in writing to:

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

All grievances must have a completed Grievance Form and be submitted along with a KEHP application. Both can be found on KEHP’s website at kehp.ky.gov.

A grievance must include ALL of the following items:

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

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

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

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

NOTE: This Grievance Committee does not review medical claims. A grievance for a medical claim must be filed with Humana.