KENTUCKY PERSONNEL CABINET

Kentucky Employees' Health Plan

SUMMARY PLAN DESCRIPTION

LIVINGWELL LIMITED HIGH DEDUCTIBLE PRESCRIPTION DRUG PLAN

Sponsored by the

Commonwealth of Kentucky

EFFECTIVE JANUARY 1, 2021

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PLAN DESCRIPTION INFORMATION

1. Proper Name of Plan: Public Employee Health Insurance Program

   Common Name of Plan: Kentucky Employees' Health Plan (KEHP)

2. Plan Sponsor and *Employer*:

   Commonwealth of Kentucky
   Personnel Cabinet
   501 High Street, Second Floor
   Frankfort, KY 40601
   (502) 564-0358

3. Plan Administrator:

   Commonwealth of Kentucky
   Personnel Cabinet, Department of Employee Insurance
   501 High Street, Second Floor
   Frankfort, KY 40601
   (502) 564-0358

4. *Employer* Identification Number: 61-0600439

5. The public employee health insurance trust fund is established in the Commonwealth of Kentucky's Personnel Cabinet. The purpose of the public employee health insurance trust fund is to provide funds to pay health insurance claims and other costs associated with the administration of the Public Employee Health Insurance Program self-insured plan.

6. The Plan provides *prescription* drug benefits for participating *employees* and their enrolled *dependents*.

7. Plan benefits described in this booklet are effective January 1, 2021

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

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

   Commonwealth of Kentucky
   Personnel Cabinet, Office of Legal Services
   501 High Street, Third Floor
   Frankfort, KY 40601
   (502) 564-7430

10. The *Plan Manager* is responsible for performing certain delegated administrative duties, including the processing of prescription drug benefit claims. The *Plan Manager* for *prescription* drug benefits is:

CVS/Caremark
PO Box 6590
Lees Summit, MO 64064-6590
Telephone: 866-601-6934

11. This is a self-insured *prescription* benefit plan. The cost of the Plan is paid with contributions shared by the *employer* and *employee*. Benefits under the Plan are provided from the general assets of the *employer* and are used to fund payment of covered claims under the Plan plus administrative expenses.

12. Each *employee* of the *employer* who participates in the Plan has access to a Summary Plan Description (SPD), which is this guide. This SPD presents an overview of *your prescription* drug benefits, provisions, and programs offered by the Plan. *Covered services* are subject to all provisions of the Plan, including any limitations and exclusions. Please read this SPD carefully.

13. This SPD will be available through the *Kentucky Employees' Health Plan's* website at kehp.ky.gov. It contains information regarding the *prescription* benefits provided and other general Plan information. For information regarding medical benefits, please refer to the Medical Benefit Booklet for *your* specific benefit plan.

14. This Plan only reflects *your prescription* drug benefit plan. This SPD should be read in conjunction with *your* applicable medical plan SPD.

15. The Plan benefits and/or contributions may be modified or amended from time to time, or may be terminated at any time by the Plan Sponsor. Significant changes to the Plan, including termination, will be communicated to *members* as required by applicable law.

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

17. The Plan does not constitute a contract between the *employer* and any *employee* and will not be considered as an inducement or condition of the employment of any *employee*. Nothing in the Plan will give any *employee* the right to be retained in the service of the *employer*, or prevent the *employer* from discharging an *employee*.

18. This Plan is not in lieu of and does not affect any requirement for coverage by Workers' Compensation insurance.

19. This Plan is included in the Commonwealth of Kentucky Flexible Benefits Plan, a cafeteria plan created pursuant to the Internal Revenue Code, Section 125. 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 at the end of this SPD. 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 this document will help *you* have a clearer understanding of this SPD.

NOTICE OF AVAILABLITY 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 at (502) 564-6534 or (888) 581-8834 or kehp.ky.gov.

SCHEDULE OF BENEFITS		
	In-network	**Out-of-network**
	Member Responsibility	
Tier 1 – Generic	50% after Deductible	60% after Deductible
Tier 2 – Brand - Value Formulary	50% after Deductible	60% after Deductible
Prescription Drug Maximum Supply is 30 days		

MAINTENANCE DRUG BENEFIT FROM MAIL ORDER AND RETAIL PHARMACY		
	In-Network	**Out-of-Network**
	Member Responsibility	
Tier 1 – Generic	50% after Deductible	Not Covered
Tier 2 – Brand - Value Formulary	50% after Deductible	Not Covered
Mail Order *Maintenance* and Retail *Maintenance Prescription* Drug Maximum is 90 days		

VALUE BENEFIT FOR DIABETES, COPD, AND ASTHMA

Diabetes, Chronic Obstructive Pulmonary Disease (COPD), and Asthma can cause serious health complications to our members. These conditions are some of *KEHP's* highest cost medical conditions, but they can often be controlled with regular doctor visits and proper medication adherence. *KEHP* cares about *you* and is offering assistance to help *you* control *your* condition(s). If *you* have diabetes, COPD or asthma, *you* will pay reduced copays and coinsurance, with no *deductible* for most all maintenance diabetes, COPD, and asthma prescriptions and supplies.

VALUE BENEFIT SCHEDULE OF BENEFITS		
	In-network	**Out-of-network**
	Member Responsibility	
Tier 1 – Generic	$0	Not Covered
Tier 2 – Brand – Value Formulary	45% no Deductible	Not Covered
Prescription Drug Maximum Supply is 30 days		

VALUE BENEFIT SCHEDULE OF BENEFITS for MAINTENANCE DRUG BENEFITS FROM MAIL ORDER AND RETAIL PHARMACY		
	In-Network	**Out-of-Network**
	Member Responsibility	
Tier 1 – Generic	$0	Not Covered
Tier 2 – Brand – Value Formulary	45% no Deductible	Not Covered
Mail Order *Maintenance* and Retail *Maintenance Prescription* Drug Maximum is 90 days		

Coinsurance amounts paid under the Value Benefit are not applied to the medical *deductible* but are applied to the annual out-of-pocket maximum.

Maintenance Value Benefit prescriptions and supplies must be a covered prescription on the maintenance drug list. See below for more information regarding *Maintenance Drugs*, or visit the *Plan Manager's* web site at www.caremark.com.

	In-Network	**Out-of-Network**
Annual Deductible *Applies to both medical & prescription benefits*	Single $4,250 Family $8,250	Single $8,250 Family $16,250
Annual Out-of-Pocket Maximum *Combined with medical benefits*	Single $5,250 Family $10,250	Single $10,250 Family $20,250
Coinsurance	Plan: 50% Member: 50%	Plan: 40% Member: 60%

PRESCRIPTION DRUG COST SHARING

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

You are responsible for payment of:

- The *coinsurance;*
- The *deductible,* except the Diabetes, COPD and Asthma Value Benefit and the *Preventive Therapy Drug Benefit;*
- The cost of any medication not covered under the *prescription* drug benefit; and
- The cost of any quantity of medication dispensed in excess of the day supply noted on the Schedule of Benefits.

If the dispensing *pharmacy's* charge is less than the *coinsurance*, *you* will be responsible for the lesser amount. The amount paid by the *Plan Manager* to the dispensing *pharmacy* may not reflect the ultimate cost to the *Plan Manager* for the drug. *Your coinsurance* is made on a per *prescription* or refill basis and will not be adjusted if the *Plan Manager* or *your employer* receives any retrospective discounts or *prescription* drug rebates. *Your coinsurance* is also made on a per *prescription* or refill basis when multiple strengths or multiple dosage forms of the same drug require the dispensing of multiple fills.

VALUE FORMULARY

The *Kentucky Employees' Health Plan* utilizes CVS/Caremark's 2021 Value Formulary. An independent group of physicians, including multiple specialists and *pharmacists*, reviews all drugs on the Value Formulary to ensure complete clinical coverage in all therapeutic categories.

2021 Value Formulary: Drugs listed on the Value Formulary may not be covered under this Plan. This SPD provides information about drugs that are not covered by the Plan, regardless of their appearance in the Value Formulary.

The Value Formulary is subject to change throughout the year. If this occurs, and you are covered under the Plan and are directly impacted by the change, you will be given notice in accordance with KRS 18A.2254.

You may request a copy of the Value Formulary by calling 866-601-6934 or by visiting CVS/Caremark's web site at www.caremark.com. *You* may also view the Value Formulary at kehp.ky.gov.

Exceptions Policy: The criteria for qualifying for a Value Formulary exception will vary from drug to drug based on the *Plan Manager's* clinical and formulary considerations. In some cases, there are clinical reasons why you may receive an override which will allow the drug to be dispensed by a *pharmacist* and the drug will be covered under the Plan. If there is no clinical reason for an override, the *Plan Manager* will determine if you have tried one or more formulary drugs, depending on the size of the drug class.

If you meet the criteria for an exception to the Value Formulary, the *Plan Manager* may issue an override. Once an override is in place, the drug excluded from the Formulary will be covered according to plan design. If an exception on a drug is approved, and would otherwise be considered a preventive drug, it will bypass the deductible, as do other drugs on the preventive therapy drug benefit. If you do not meet the criteria for an exception, the override request will be denied. You may appeal the denial in accordance with the Appeal provisions outlined in this SPD.

To request a formulary exception, you or your provider must call or submit a written request for a formulary exception to:

CVS/Caremark
MC 109
PO Box 52084
Phoenix, AZ 85072-2084
Phone: 866-443-1183
Fax: 866-443-1172

PRESCRIPTION DRUG COVERAGE

You must call 866-601-6934 or visit the *Plan Manager's* web site at www.caremark.com to verify whether a *prescription* drug is covered or not covered under the Plan.

Covered *prescription* drugs, medicine, or medications must:

1. Be prescribed by a *physician* for the treatment of a covered *sickness* or *bodily injury*; and

2. Be dispensed by a *pharmacist*.

Notwithstanding any other provisions of the Plan to the contrary, *prescription* drug expenses covered under the Prescription Drug Benefit are not covered under any other provisions of the Plan. Any amount in excess of the maximum amount provided under the Prescription Drug Benefit is not covered under any other provision of the Plan. Most *expenses incurred* under provisions of the *Prescription* Drug Benefit section apply toward *your* deductible and out-of-pocket maximum. There will be no *deductible* under the Diabetes, COPD and Asthma Value Benefit., and the Preventive Therapy Drug Benefit. *Coinsurance* amounts paid under the Diabetes, COPD and Asthma Value Benefit, and the Preventive Therapy Drug Benefit List do not apply toward the *deductible* but are applied toward the annual out-of-pocket maximum.

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

WELL-BEING PROGRAM DISCLOSURE

LivingWell is KEHP's voluntary wellness program available to all persons who enroll in a KEHP health insurance plan or who waive health insurance coverage. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease. Those federal rules include the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program, you will be asked to complete a voluntary health assessment or "HA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). In lieu of completing an HA, you may complete a biometric screening, which will include a blood test to check your cholesterol and blood glucose levels. You are not required to complete the HA or to participate in the biometric screening or any other medical examination. However, employees who choose to participate in the LivingWell wellness program will receive an incentive in the form of discounted employee premium contributions for your health insurance coverage. Although you are not required to complete the HA or participate in the biometric screening, only employees who do so will receive the discounted health insurance premiums.

Additional incentives in the form of gift cards, consumer goods, and other prizes may be available for employees who participate in certain health-related activities such as walking challenges or quitting smoking. In addition, KEHP offers discounted, monthly employee premium contribution rates to non-tobacco users. Each KEHP member has at least one opportunity per Plan Year to qualify for the monthly premium contribution discount.

KEHP is committed to helping you achieve your best health. Incentives for participating in KEHP's LivingWell wellness program are available to all persons who enroll in a KEHP health insurance plan or who waive health insurance coverage. If you are unable to participate in any of the health-related activities, or you think you might be unable to meet a standard to earn an incentive under the LivingWell wellness program, you may request a reasonable accommodation or an alternative standard. Contact the Department of Employee Insurance, Member Services Branch at (888) 581-8834 or (502) 564-6534 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same incentive that is right for you in light of your health status.

Protections from Disclosure of Medical Information: KEHP is required by law to maintain the privacy and security of your personally identifiable health information. KEHP does not collect or retain personal health or medical information through its LivingWell wellness program; however, KEHP may receive and use aggregate information that does not identify any individual in order to design programs based on health risks identified in the workplace and that are aimed at improving the health of KEHP members. KEHP will never disclose any of your personal information either publicly or to your employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program. You will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individuals who may receive your personally identifiable health information are persons employed

by StayWell (KEHP's wellness administrator) and Anthem (KEHP's third-party medical administrator). This may include nurses in Anthem's disease management program and health coaches in StayWell's health coaching program. Disclosure of your personally identifiable health information to these persons is necessary in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records; information stored electronically will be encrypted; and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach. In the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you as soon as it is feasible after discovery of the breach.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the LivingWell wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the Department of Employee Insurance, Member Services Branch at (888) 581-8834 or (502) 564- 6534

TOBACCO CESSATION

The *Prescription* Drug Benefit under the Plan provides coverage for certain *over-the-counter* (OTC) nicotine replacement therapies at no cost to the *member* if prescribed by a physician or if the *KEHP member* is participating in an approved tobacco cessation program. To learn more about *KEHP's* tobacco cessation programs, call Member Services at (502) 564-6534 or 888-581-8834 or visit KEHPlivingwell.com.

CVS/CAREMARK SPECIALTY PHARMACY—SPECIALTY DRUGS

KEHP uses the *CVS/Caremark Specialty Pharmacy* for specialty drugs used to treat complex conditions. The *CVS/Caremark Specialty Pharmacy*, a wholly owned subsidiary of CVS/Caremark, is a national provider of specialty *pharmacy services* offering a broad range of healthcare products and *services* for individuals with complex health conditions such as growth hormone deficiencies, hepatitis C, hemophilia, HIV/AIDS, cancer, multiple sclerosis, rheumatoid arthritis, and many others. *CVS/Caremark Specialty Pharmacy* provides comprehensive patient management services including clinical case management programs, counseling, education, and social services. Medications will be ordered specifically for *you* and delivered to *your* home or a location of *your* choice.

CVS/Caremark Specialty Pharmacy specializes in specialty medications. *CVS/Caremark Specialty Pharmacy* offers many products and *services* that *you* do not get from other *pharmacies*. Most importantly, *CVS/Caremark Specialty Pharmacy* has a complete specialty *pharmacy* inventory with many specialty medications that are not readily available at a local *pharmacy*. *CVS/Caremark Specialty Pharmacy*:

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

CVS/Caremark Specialty Pharmacy will allow *you* to receive *your* first *prescription* in the HIV and transplant therapeutic categories from any *participating pharmacy*. Initial fills of specialty *prescriptions* in other therapeutic classes and all refill specialty *prescriptions* are limited to dispensing from *CVS/Caremark Specialty Pharmacy*. *CVS/Caremark Specialty Pharmacy* will manage all of *your prescriptions* and a Patient Care Coordinator will work with *you* to ensure *you* receive the care *you* need. *Your* specialty drugs will be delivered to *your* home within a reasonable time, usually within 24 hours. Included with *your* specialty drugs will be all *your* needed supplies – needles, syringes, alcohol swabs and sharps containers, at no additional cost to *you*.

Additional information, including a current listing of the drugs that must be purchased through the *CVS/Caremark Specialty Pharmacy* can be obtained by calling 800-237-2767.

PREVENTIVE THERAPY DRUG BENEFIT

The Preventive Therapy Drug Benefit is a listing of preventive therapy drugs that help prevent disease or manage an existing condition, which helps to avoid further medical complications. The preventive therapy drug benefit provides coverage for FDA-approved medications deemed preventive based on the guidance provided by Internal Revenue Service under NOTICE 2004-23 and Section 223 (c)(2)(C) of the Internal Revenue Code.

If *you* take a medication listed on the Preventive Therapy Drug Benefit List, *you* may bypass the *deductible* and pay only the applicable *coinsurance*, even if *you* have not yet met *your deductible*. The Preventive Therapy Drug Benefit listing can be found at kehp.ky.gov.

COMPOUND DRUGS

Compounding for specialty *prescriptions* will be available only through *CVS/Caremark Specialty Pharmacy*. Compounded drug products that are equal to or greater than $300 will be subject to a *prior authorization* to ensure the final compounded drug is FDA-approved for the indication, intended use, dose, and route of administration. A compound drug will not be authorized unless all ingredients in the compounded drug are FDA-approved drugs. Compound drugs are not covered if they are used for a purpose, *sickness*, or *bodily injury* not covered by the Plan or are topical compounds, topical compound kits, compounds for anti-aging, cosmetic use, compound kits, compounds that contain a bulk powder, dietary supplements, or hormone therapy compounds (e.g. testosterones, estrogens, progestins, bioidentical hormones) for menopause or for androgen decline due to aging.

STEP THERAPY

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

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

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

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

Drugs Requiring Step Therapy: To determine if a *prescription* drug requires Step Therapy, call 866-601-6934 or visit the *Plan Manager's* web site at www.caremark.com.

PRIOR AUTHORIZATION

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

Prior Authorization Hotline: The most efficient way to initiate a *prior authorization* review is to ask *your* physician to contact CVS/Caremark's *prior authorization* hotline at 800-294-5979. If the request is approved, an override is entered. If the request is not approved, a follow-up letter will be mailed to *you* and *your* physician.

Prior Authorization Form: *Your* physician may also fax a *prior authorization* form to CVS/Caremark. *Prior authorization* forms may be obtained from CVS/Caremark at 866-601-6934. *Prior authorization* forms may only be completed by *your* physician or *pharmacist*.

Drugs Requiring Prior Authorization: To verify if a *prescription* drug requires *prior authorization*, call 866-601-6934 or visit the *Plan Manager's* web site at www.caremark.com.

WHY WEIGHT KENTUCKY

KEHP will cover certain *prescription* drugs if *you* are enrolled in the Why Weight Kentucky program. *Members* in a chronic condition management program that have weight management needs and have expressed an interest in weight loss medications will be enrolled. Why Weight Kentucky participants will follow a weight management care plan provided by their program nurse, which is designed to assist in achieving and maintaining a healthy weight. Call 1-844-402-5347 to speak to a representative about Why Weight Kentucky.

QUANTITY LEVEL LIMITS (QLL)

Some *prescriptions* are subject to *Quantity Level Limits (QLL).* A *QLL* is placed on a *prescription* drug that should be limited in quantity, day supply, and/or number of months. *QLLs* ensure that *you* receive the

medication *you* need in the quantity that is considered safe and recommended by the drug manufacturer, the U.S. Food & Drug Administration (FDA), and clinical studies.

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

If *you* are prescribed an opioid medication, *you* will be subject to opioid management which includes stricter quantity limits on opioid medications to help prevent misuse, overuse, and abuse, based on guidelines of the Center for Disease Control (CDC).

To verify if a *prescription* drug is subject to *QLL*, call 866-601-6934 or visit the *Plan Manager's* web site at www.caremark.com.

RETAIL PHARMACY

Your Plan includes a retail *prescription* drug benefit. To access this benefit, *you* must present *your* health insurance identification (ID) card at a *participating pharmacy* when purchasing *your prescription. Prescriptions* dispensed at a retail *pharmacy* are limited to a thirty (30) day supply per *prescription* or refill, except as provided under the *Maintenance Drug* Benefit below.

MAINTENANCE DRUG BENEFIT— MAIL ORDER AND RETAIL PHARMACY

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

Mail Order through CVS/Caremark Pharmacy: If *you* have *your prescription* filled by the CVS/Caremark mail order *pharmacy*, *your prescription*s will be shipped to *your* home address saving *you* time and, many times mail order costs less. The mail order benefit allows *you* a ninety (90) day supply of *your maintenance drugs.* Refer to the Schedule of Benefits on page 4 for more details.

Retail Pharmacy: If *you* have *your maintenance* drug *prescription* filled by a *participating* retail *pharmacy*, *you* may receive a ninety (90) day supply. *Participating pharmacies* must meet the terms and conditions for participation in the provider network established by CVS/Caremark, including price and dispensing fee.

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

- 90-day supply per *prescription* or refill from CVS/Caremark mail order *pharmacy*; or a
- 90-day supply per *prescription* or refill from a *participating pharmacy*.

Maintenance Drug Benefits shall not permit the dispensing of a controlled substance classified in Schedule II-V – either through CVS/Caremark mail order or the retail *pharmacy*. The *Maintenance Drug* Benefit also shall not permit the dispensing of *most* controlled substances through the retail *pharmacy*.

Additional *Maintenance Drug*—mail order *pharmacy* information can be obtained by calling 866-601-6934 or by visiting the *Plan Manager's* web site at www.caremark.com.

NON-PARTICIPATING PHARMACY

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

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

You will have 180 days from the date the *prescription* is filled to file the *prescription* claim with CVS/Caremark.

To file a *prescription* claim from a *non-participating pharmacy*, mail *pharmacy* receipts to:
CVS/Caremark, Attn: Commercial Clams, P.O. Box 52136, Phoenix, AZ 85072-2136.

INBORN ERRORS OF METABOLISM or GENETIC CONDITION

This benefit is available through the medical plan. The *Plan Manager* will provide benefits for *therapeutic food, formulas, supplements* and *low-protein modified food* products for the treatment of inborn errors of metabolism or genetic conditions if the *therapeutic food, formulas, supplements*, and *low-protein modified food* products are obtained for the therapeutic treatment of inborn errors of metabolism or genetic conditions under the direction of a physician. Inborn errors of metabolism or genetic conditions include, but are not limited to, the following conditions:

> Phenylketonuria; Hyperphenylalaninemia; Tyrosinemia (types I, II, and III); Maple syrup urine disease; A-ketoacid dehydrogenase deficiency; 3-methylcrotonyl-CoA carboxylase deficiency; 3-methylglutacony1-CoA hydratase deficiency; 3-hydroxy-3-methylglutaryl-CoA lyase deficiency (HMG-CoA lyase deficiency); B-ketothiolase deficiency; Homocystinuria; Glutaric aciduria (types I and II); Lysinuric protein intolerance; Non-ketotic hyperglycinemia; Propionic academia; Gyrate atrophy; Hyperornithinemia/hyperammonemia/homocitrullinuria syndrome; Carbamoyl phosphate synthetase deficiency; Ornithine carbamoyl trasferase deficiency; Citrullinemia; Arginosuccinic aciduria; Methylmalonic academia; and Argininemia.

Coverage under this benefit is subject to a *plan year* benefit maximum of $25,000 for *therapeutic food, formulas, and supplements* and a separate *plan year* benefit maximum of $4,000 for *low-protein modified foods*. *Therapeutic food, formulas, supplements*, and *low-protein modified food* products for the treatment of inborn errors of metabolism or genetic conditions are payable through the medical benefit .

This benefit does not include coverage for *therapeutic foods, formulas, supplements* or *low-protein modified food* for the treatment of lactose intolerance, protein intolerance, food allergy, food sensitivity, or any other condition or disease that is not an inborn error of metabolism or genetic condition.

PRESCRIPTION DRUG EXCLUSIONS

Expenses incurred will not be payable for the following:

1. Any drug, medicine, medication, or supply not authorized or otherwise approved for coverage under the Plan;
2. *Legend drugs* which are not recommended and not deemed necessary by a *physician*;
3. More than two fills for the same drug or *therapeutic equivalent* medication prescribed by one or more *physicians* and dispensed by one or more retail *pharmacies*;
4. Charges for the administration or injection of any drug, except for vaccines;
5. Drug delivery implants for uses other than contraception;
6. Any drug, medicine, or medication labeled "Caution-Limited by Federal Law to Investigational Use," or experimental drug, medicine, or medication, even though a charge is made to *you*;
7. Any drug, medicine, or medication that is consumed or injected at the place where the *prescription* is given, or dispensed by the *physician*, except for vaccines;
8. *Prescriptions* that are to be taken by or administered to the *covered person*, in whole or in part, while he or she is a patient in a facility where drugs are ordinarily provided by the facility on an inpatient basis. Inpatient facilities include, but are not limited to:
    a. Hospitals;
    b. Skilled nursing facilities; or
    c. Hospice facilities;
9. Any drug prescribed for a use other than its intended use except for:
    a. Indications approved by the FDA; or
    b. Recognized off-label indications through peer-reviewed medical literature;
10. *Prescription* doses that exceed FDA-approved maximum doses and *prescriptions* for which the method or route of administration of the *prescription* is not FDA-approved.
11. *Prescription* refills:
    a. In excess of the number specified by the *physician*; or
    b. Dispensed more than one year from the date of the original order;
12. Any drug for which a charge is customarily not made;
13. Therapeutic devices or appliances, including: hypodermic needles and syringes (except needles and syringes for use with insulin, and covered *self-administered injectable drugs*); support garments; test reagents; mechanical pumps for delivery of medication (except for insulin pumps and supplies); and other non-medical substances, unless otherwise specified by the Plan;
14. Dietary supplements, nutritional products, minerals, herbs and vitamins (except pre-natal vitamins, including greater than one milligram of folic acid, and pediatric multi-vitamins with fluoride), unless otherwise specified by the Plan;
15. Compound drug products used for an indication, purpose, sickness, or bodily injury not covered by the plan; compound drug products that contain ingredients that are not FDA-approved drugs; topical compounds, topical compound kits; compounds for anti-aging or cosmetic use; compound kits, compounds that contain a bulk powder; dietary supplements; or hormone therapy compounds (e.g. testosterones, estrogens, progestins, bioidentical hormones) for menopause or for androgen decline due to aging.
16. Injectable drugs, including but not limited to: immunizing agents that are given at skilled facilities, biological sera, blood, blood plasma, heparin and saline IV flushes, or *self-administered injectable drugs* not covered under the Plan;
17. Any drug prescribed for a *sickness* or *bodily injury* not covered under the Plan;
18. Any portion of a *prescription* or refill that exceeds a thirty (30) day supply (or a ninety (90) day supply for a *prescription* or refill received from the *Maintenance Drug* Benefit.);
19. Any portion of a prescription that exceeds the drug specific quantity limit;

20. Any prescription dispensed to a covered person whose age is outside the drug specific age limits;
21. Any prescription that exceeds the duration-specific dispensing limit;
22. Any drug, medicine, or medication received by the *covered person*:
    a. Before becoming covered under the Plan; or
    b. After the date the *covered person's* coverage under the Plan has ended;
23. Any costs related to the mailing, sending, or delivery of *prescription* drugs;
24. Any fraudulent misuse of this benefit including *prescriptions* purchased for consumption by someone other than the *covered person*;
25. *Prescription* or refill for drugs, medicines, or medications that are spilled, spoiled, or damaged;
26. Any drug or medicine that is lawfully obtainable without a *prescription* (*over-the-counter* drugs), except insulin and certain preventive drugs;
27. Any drug or biological that has received an "*orphan drug*" designation, unless approved by the Plan Administrator;
28. Any amount *you* paid for a *prescription* that has been filled, regardless of whether the *prescription* is revoked or changed due to adverse reaction or change in dosage or *prescription*;
29. More than one *prescription* within a 23-day period for the same drug or *therapeutic equivalent* medication prescribed by one or more *physicians* and dispensed by one or more *pharmacies*, unless received from a mail order *pharmacy*. For drugs received from a mail order *pharmacy*, more than one *prescription* within a 20-day period for a 1-30 day supply; or a 60-day period for a 61-90 day supply. (Based on the dosage schedule prescribed by the *physician*);
30. Homeopathic products;
31. Depigmentation products;
32. Topical and injectable cosmetic products;
33. Scar treatment products;
34. Hair growth or hair removal products;
35. Erectile dysfunction products and impotency drugs;
36. Non-ACA preventive vaccines are not covered under the pharmacy benefit, including but not limited to, vaccinations for Japanese Encephalitis, rabies, yellow fever, anthrax, and typhoid;
37. OTC, injectable, and non-FDA approved allergens;
38. Durable medical equipment;
39. Drugs that are not approved by the FDA;
40. Medications that are pre-packaged into *unit dose* packaging;
41. *Prescription* drugs that have an *Over-the-Counter (OTC)* equivalent available;
42. Infertility drugs, regardless of the diagnosis; and
43. Drugs that are excluded from the Value Formulary. For some prescription drugs excluded from CVS/Caremark's standard and specialty Formularies, this Plan has an Exceptions Policy that may allow you to obtain a non-covered medication. For those exclusions, if certain criteria are met, you can receive a non-covered drug. For more information, please call 866-601-6934.
44. Products on CVS/Caremark's Miscellaneous Formulations Exclusion List, which include but are not limited to scar creams and patches, convenience multi-product kits, and other dermatologicals and analgesics.
45. Medical devices, including products with a 510k certification, except products used for diabetic testing, insulin administration and ACA Preventive mandated products.
46. Wound care products, including oral rinses, marketed without FDA-approval via a New Drug Application, Abbreviated New Drug Application, or Biologics License Application.
47. Dermatological products marketed without FDA-approval via a New Drug Application, Abbreviated New Drug Application, or Biologics License Application.

MEDICAL BENEFITS BOOKLET

The Medical Benefits Booklet contains information not found in the *prescription* drug SPD. Please refer to *your* Medical Benefits Booklet for information regarding the following:

- *KEHP* eligibility;
- Plan Reimbursement and Subrogation;
- Enrollment, including special enrollment rights under the Health Insurance Portability and Accountability Act of 1996 and the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA);
- Continuation of benefits under COBRA;
- Mastectomy-related benefits in accordance with the Women's Health and Cancer Rights Act of 1998 (WHCRA);
- *Your* rights under the Newborns' and Mothers' Health Protection Act of 1996;
- *Your* rights to reinstate coverage under the Uniformed Services Employment and Reemployment Rights of 1994;
- Compliance with the Mental Health Parity Act (MHPA) and Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA); and
- Compliance with the Genetic Information Nondiscrimination Act of 2008 (GINA).

You may obtain a copy of *your* Medical Benefits Booklet at kehp.ky.gov.

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. Coordination of Benefits is a provision establishing an order in which plans pay their claims, and permitting secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed the total allowable expenses. Coordination of Benefits prevents duplication of coverage and a resulting increase in the cost of medical coverage.

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

Allowable expense means any *eligible expense*, a portion of which is covered under one of the plans covering the person for whom a *claim* is made. Each plan will determine an allowable expense according to the provisions of the respective plan. When a plan provides benefits in the form of *services* rather than cash payments, the reasonable cash value of each *covered 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. The primary plan is a plan whose benefits for a person's health care coverage shall be determined without taking

the existence of any other plan into consideration. All other plans are called secondary plans.

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

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

1. The plan has no coordination of benefits provision;

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

3. For a child who is covered under both parents' plans and the parents are married, the plan covering the parent whose birthday (month and day) occurs first in the *calendar year* pays before the plan covering the other parent. If the birthdates of both parents are the same, the plan which has covered the person for the longer period of time will be determined the primary plan; If a plan other than this Plan does not include provision 3, then the gender rule (male's coverage pays primary) will be followed to determine which plan is primary.

4. In the case of *dependent* children covered under the plans of divorced or separated parents, the following rules apply:

    a. The plan of a parent who has custody will pay the benefits first;

    b. The plan of the spouse of the custodial parent (step-parent) will pay benefits next;

    c. The plan of a parent who does not have custody will pay benefits next;

    d. The plan of the spouse of the noncustodial parent (step-parent) will pay benefits next.

5. Court Decree: 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.

    If a court decree states that one parent is responsible for a dependent child's health care expenses or health care coverage and the plan of the parent has actual knowledge of those terms, that plan is primary. If the parent with financial responsibility has no coverage for the child's health care *services* or expenses, but that parent's spouse does, the spouse's plan is primary.

6. 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.

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

COORDINATION OF BENEFITS WITH *MEDICARE*

In all cases, Coordination of Benefits with *Medicare* will conform to Federal Statutes and Regulations. In the case of *Medicare,* each individual who is eligible for *Medicare* will be assumed to have full *Medicare* coverage (i.e. Part A hospital insurance and Part B voluntary medical insurance) whether or not the

individual has enrolled for full coverage. *Your* benefits under the Plan will be coordinated to the extent benefits would otherwise have been paid under *Medicare* as allowed by Federal Statutes and Regulations.

TRICARE AS SECONDARY PAYER:

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

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

RIGHT OF RECOVERY AND OTHER GENERAL PROVISIONS

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

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

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

1. Made in error; or

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

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

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

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

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

2. No final determination is made that *bodily injury* or *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 the Plan, *you* will notify the *Plan Manager* of any Workers' Compensation claim *you* make, and that *you* agree to reimburse the Plan as described above.

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

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

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

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

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

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

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

PRIVACY OF PROTECTED HEALTH INFORMATION

The Plan Administrator understands the importance of keeping *protected health information (PHI)* confidential. *PHI* includes both medical information and individually identifiable information, such as a covered person's name, address, telephone number, or Social Security number. The Plan Administrator collects and maintains protected health information that includes personal identifiers, enrollment, eligibility, and dependent and qualifying event information. The Plan Administrator utilizes third parties, including a third-party claims administrator and a *pharmacy* benefits manager, referred to as "Business Associates," to carry out certain functions for the Plan. Because of their administrative responsibilities, these Business Associates create, receive, maintain, and transmit PHI on behalf of the Plan. Like the Plan Administrator, the Business Associates are responsible for ensuring the protection of *your* health information. The *Plan Manager* is the Plan Administrator's Business Associate.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires the Plan Administrator and its Business Associates, including the *Plan Manager*, to maintain the privacy of *your* PHI and notify *you* following a breach of unsecured PHI. HIPAA permits the Plan Administrator and its

Business Associates to use and disclose PHI for treatment, payment, or health care operations including, but not limited to, claims processing, billing, case management, provider credentialing, and utilization review. Other uses and disclosures, whether limited, permitted, or required by HIPAA, are outlined in *KEHP's* Notice of Privacy Practices.

KEHP's Notice of Privacy Practices and associated forms may be obtained by visiting kehp.ky.gov or *you* can request a copy of the Notice of Privacy Practices by writing to:

Personnel Cabinet
Department of Employee Insurance
Attn: Privacy Officer
501 High Street, 2nd Floor
Frankfort, KY 40601

To the extent required and permitted by law, when using or disclosing PHI, the Plan Administrator and its Business Associates will make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use or disclosure.

By enrolling in the Plan, a *covered person* will be deemed to have consented to the permitted, required, and limited uses and disclosure of protected health information, as outlined in *KEHP's* Notice of Privacy Practices. Any *covered person* who may not have intended to provide this consent and who does not so consent must contact the Plan Administrator prior to filing any claim for Plan benefits, as coverage under the Plan is contingent upon consent.

The *Plan Manager* will afford access to PHI in its possession only as necessary to discharge its obligations as a Business Associate of the Plan Administrator, within the restrictions noted above and in accordance with *KEHP's* Notice of Privacy Practices. *Plan Manager* may have PHI not in the possession of the Plan Administrator; however, Plan records that include PHI are the property of the Plan. Information received by the *Plan Manager* is information received on behalf of the Plan. The *Plan Manager* will afford access to PHI as reasonably directed in writing by the Plan Administrator, which shall only be made with due regard for confidentiality and in accordance with *KEHP's* Notice of Privacy Practices.

Covered persons have certain rights regarding their PHI maintained by the Plan Administrator and its Business Associates, including the right to amend PHI, inspect and copy PHI, and request restrictions on uses and disclosures of PHI. Covered persons may authorize the Plan Administrator and its Business Associates to release their PHI for purposes and to persons other than as permitted by *KEHP's* Notice of Privacy Practices. Covered persons may also file a complaint if they believe their privacy rights have been violated. These rights and procedures regarding these rights are outlined in *KEHP's* Notice of Privacy Practices.

Covered persons may be required to make requests or assert their rights regarding PHI directly to the *Plan Manager* in the event the Plan Administrator is not in the possession of the applicable PHI that is the subject matter of the request or assertion.

CLAIMS PROCEDURES

Notice of Claim: Written notice of a claim must be given to the *Plan Manager* within 180 days after the date of loss, except if the *covered person* was legally incapacitated. Notice of a claim may be given to the *Plan Manager* as described in the How to File a Prescription Drug Claim section.

How to File a Prescription Drug Claim:

1. *You* will receive a health insurance identification (ID) card that will contain information regarding *your* coverage under the Plan. Present *your* ID card to the *pharmacy* to fill a *prescription*.

2. Due to the Assignment provisions described below, most *prescriptions* are processed through the *pharmacy* at the time *your prescription* is filled without the necessity of filing a paper claim with the *Plan Manager*. However, the presentation of a *prescription* to a *pharmacy* does not constitute a claim. If a *covered person* is required to pay the cost of a covered *prescription* drug, he or she may submit a claim based on that amount to the *Plan Manager*.

3. When it is necessary to file a paper claim, such as receiving *covered services* from an out-of-network *pharmacy*, *you* must mail *your prescription* drug claims to the *Plan Manager* at the following address:

   CVS/Caremark
   Attn: Commercial Clams
   P. O. Box 52136
   Phoenix, AZ 85072-2136

4. Claim forms are available by calling 866-601-6934.

5. 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;
   h. The *prescription* number;
   i. The name of the drug;
   j. The date filled; and
   k. The date purchased.

6. Claims will not be deemed submitted for purposes of these procedures unless and until received at the correct address.

7. Claims submissions must be in a format acceptable to the *Plan Manager* and compliant with any applicable legal requirements. Claims that are not submitted in accordance with the requirements of applicable federal law respecting privacy of PHI and/or electronic claims standards will not be accepted by the Plan.

8. Claims submissions must be timely. *You* must give written proof of loss in the form of a claim within 180 days after the date of loss, except if *you* were legally incapacitated.

9. Plan benefits are only available for claims that are incurred by a *covered person* during the period that he or she is covered under the Plan.

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

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

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

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

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

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.

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

Payments due under the Plan will be paid within 30 days of receipt of written proof of loss in the form of notice of a claim.

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

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

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

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

designation to have been made. An assignment of benefits does not constitute designation of an authorized representative.

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

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

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

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

1. PRE-SERVICE CLAIMS

The *Plan Manager* will notify the claimant of the Plan's benefit determination, whether favorable or adverse, within a reasonable period of time appropriate to the medical circumstances, but no later than 5 days after receipt of the pre-service claim and all n*ecessary information* by the *Plan Manager*. This period may be extended one time up to an additional 5 days if the *Plan Manager* determines that such an extension is necessary due to matters beyond the control of the Plan or the *Plan Manager*. The *Plan Manager* will notify the affected claimant of the extension prior to the expiration of the initial 5-day period, the circumstances requiring the extension, and the date by which the Plan expects to make a decision.

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

2. URGENT CARE CLAIMS

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

The *Plan Manager* will notify the claimant of the Plan's benefit determination, whether favorable or adverse, as soon as possible, taking into account the medical exigencies particular to the claimant's situation, but not later than 24 hours after receipt of the urgent care claim and all n*ecessary information* by the *Plan Manager*.

However, if a claim is submitted that does not provide sufficient information to determine whether, or to what extent, expenses are covered or payable under the Plan, the *Plan Manager* will notify the claimant as

soon as possible, but not more than 24 hours after receipt of the urgent care claim by the *Plan Manager*. The notice will describe the specific information necessary to complete the claim.

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

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

- The *Plan Manager's* receipt of the specified information; or

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

3. CONCURRENT CARE DECISIONS

If the Plan has approved an ongoing course of treatment to be provided over a period of time or a number of treatments, the *Plan Manager* will notify a claimant of a *concurrent care decision* that involves a reduction in or termination of such course of treatment (other than by plan amendment or termination) that has been pre-authorized. The *Plan Manager* will provide the notice sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of the adverse determination before the benefit is reduced or terminated.

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

4. POST-SERVICE CLAIMS

The *Plan Manager* will notify the claimant of the Plan's benefit determination, whether favorable or adverse, within a reasonable time, but not later than 30 days after receipt of the claim and all *necessary information* by the *Plan Manager*. This period may be extended one time up to an additional 15 days if the *Plan Manager* determines that such an extension is necessary due to matters beyond the control of the Plan or the Plan Manager. The *Plan Manager* will notify the affected claimant of the extension prior to the expiration of the initial 30-day period, the circumstances requiring the extension, and the date by which the Plan expects to make a decision.

If the reason for the extension is because of the claimant's failure to submit information necessary to decide the claim, the notice of extension will describe the required information.

a. The claimant will have at least 45 days from the date the notice is received to provide the specified information.

b. The *Plan Manager* will make a decision no later than 15 days after the earlier of:
   - The *Plan Manager's* receipt of the specified information; or

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

Times for Decisions: The periods of time for claims decisions presented above begin when a claim is

received by the *Plan Manager*, in accordance with these claims procedures.

In the event a period of time is extended as permitted by these claims procedures due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

INTERNAL APPEALS AND EXTERNAL REVIEW

INTERNAL APPEALS

Definitions: If *your prescription* has been denied, *you* have the right to file an appeal of that determination. The following section outlines *your* rights and the procedures for filing an appeal.

1. **Adverse Determination** means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, based on a determination of a *member's* eligibility to participate in the Plan, and including a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any *utilization review*, as well as a failure to cover an item or *service* for which benefits are otherwise provided because it is determined to be experimental or investigational or not *medically necessary* or appropriate. An Adverse Determination does not mean a determination that the healthcare *services* are not covered services. The *Plan Manager* is responsible for the Internal Appeal Process for Adverse Determinations in accordance with KRS 304.17A-600 through 633.

2. **Coverage Denial** means the Plan's determination that a service, treatment, drug or device is specifically limited or excluded under the *covered person*'s plan. The *Plan Manager* is responsible for the Internal Appeal Process for Coverage Denials in accordance with KRS 304.17A-600 through 633.

3. **Administrative Appeals** are for situations that do not fall in the category of either adverse determinations or coverage denials. For example, a *member* feels his/her cost should be reduced from what is determined by the Plan (i.e. a drug is covered on the *Tier 2* and the *member* feels the drug should be covered as under *Tier 1*.). The Plan Administrator is responsible for handling Administrative Appeals.

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

Initial Complaint – before filing an Internal Appeal, a *covered person* should always contact the *Plan Manager's* Customer Service Department first at 866-601-6934. Many problems can be resolved the same day. If not, the member services representative will investigate and contact the *member* with the findings and any action taken to resolve the complaint. If a member's complaint is related to a denial of coverage or other decision by the *Plan Manager*, the *member* may file an Internal Appeal.

Internal Appeal - If the Initial Complaint is not resolved to the satisfaction of the *covered person*, the *covered person* may request an internal appeal. A request for an Internal Appeal must be submitted in writing within 180 days of receipt of a denial letter.

To appeal a denial of a *prescription drug*, the *covered person*, authorized person, or provider acting on behalf of a *covered person* should file an appeal to:

CVS/Caremark
Attn: Appeals
MC 109
PO Box 52084
Phoenix, AZ 85072-2084

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

- The *employee's* name and *covered person's* name.
- The *member's Kentucky Employees' Health Plan* Identification Number (found on the *member's* health insurance identification card).
- The *member's* address and daytime phone number.
- A copy of the initial denial letter.
- The *service* being denied.
- All facts and issues related to the denial of the claim, including the names of providers involved, medical records, and any other documentation relevant to the denied claim.

In deciding an Internal Appeal of an Adverse Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not *medically necessary* or appropriate, the Internal Appeal review will be conducted by a licensed physician who did not participate in the initial review and denial. If the denial is for an Adverse Determination and the *service* requires a medical or surgical specialty or subspecialty, the *covered person*, authorized person, or provider may request that a board eligible or certified physician from the appropriate specialty or subspecialty conduct the Internal Appeal.

The Internal Appeal review will take into account all comments, documents, records, and other information submitted by the *covered person*, the authorized person, or the provider relating to the claim, without regard to whether such information was submitted or considered in the initial Adverse Determination. The *covered person*, authorized person, or provider will be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by the *Plan Manager* in connection with the claim. In such case, the *covered person*, authorized person, or provider will be afforded a reasonable opportunity to respond to the additional evidence relied upon, prior to the date on which the notice of the Internal Appeal determination is required to be made.

The *Plan Manager* will notify the *covered person*, authorized person, or provider of the Internal Appeal decision on the Adverse Determination within thirty (30) calendar days of receipt of the Internal Appeal request by the *Plan Manager*. The *Plan Manager*'s failure to make a determination or provide a written notice within the 30-day timeframe will be deemed to be an Adverse Determination for the purpose of initiating an External Appeal.

If the *covered person*, authorized person, or provider has new clinical information regarding the *covered person's* Internal Appeal, he or she shall provide that information to the *Plan Manager* prior to the initiation of the External Appeal process. The *Plan Manager* will have five (5) business days from the date of receipt of the information to render a decision based on the new information. If new information is provided, the timeframe for commencing an External Review will not begin to run until the *Plan Manager* renders a decision regarding the new information.

To appeal a denial of a *prescription drug*, the *covered person*, authorized person, or provider acting on behalf of the *covered person* must file an appeal to:

CVS/Caremark
Attn: Appeals
MC 109
PO Box 52084
Phoenix, AZ 85072-2084

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

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

The *Plan Manager* shall render a decision not later than twenty-four (24) hours after receipt of the request for an expedited appeal of an Adverse Determination or Coverage Denial, unless the *covered person* fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. The expedited appeal may be requested orally with a follow-up letter.

At any time during the internal appeal, additional pertinent information may be submitted for consideration. All *necessary information*, including the Plan's benefit determination on review, may be transmitted between the *Plan Manager* and the *covered person*, authorized person, or provider by telephone, facsimile, or other available similarly expeditious method.

Deemed Exhaustion: If the *Plan Manager* fails to adhere to the requirements of the Internal Appeals process with respect to a claim, the *covered person* is deemed to have exhausted the Internal Appeals process. In such case, the *covered person* may initiate an External Appeal.

The Internal Appeals process will not be deemed exhausted based on *de minimus* violations that do not cause, and are not likely to cause, prejudice or harm to the *covered person* so long as the *Plan Manager* demonstrates that the violation was for good cause or due to matters beyond the control of the insurer and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the *covered person*.

- The *covered person* may request a written explanation of the failure to comply with the Internal Appeal procedure from the *Plan Manager*;
- The *Plan Manager* will provide an explanation within 10 days, including a specific description of its bases, if any, for asserting the failure should not cause the Internal Appeals process to be deemed exhausted;
- If an external reviewer rejects the *covered person's* request for immediate review on the basis that the Plan met the standards for the de minimus exception, the *covered person* has the right to resubmit and pursue the Internal Appeal of the Adverse Determination;
- If an external reviewer rejects the claim for immediate review, the *Plan Manager* will provide the *covered person* with notice of the opportunity to resubmit and pursue the Internal Appeal of the claim;
- Time periods for re-submitting the Adverse Determination for Internal Appeal will begin to run upon the *covered person's* receipt of notice of the rejection of immediate review by External Appeal.

Appeal of a Prescription Drug Formulary Change: The *Plan Manager* will provide written notice of any *prescription* drug Advanced Control Formulary change to covered persons under the Plan who are directly impacted by the Advanced Control Formulary change and to the Kentucky Group Health Insurance Board fifteen (15) days before implementation of any Advanced Control Formulary change. If, after consulting with his or her physician, the *covered person* disagrees with the Advanced Control Formulary change, the *covered person* shall have the right to appeal the Advanced Control Formulary change.

The *covered person* will have sixty (60) days from the date of the notice of the Advanced Control Formulary change to file an appeal with the *Plan Manager*. The *Plan Manager* will render a decision within thirty (30) days from the receipt of the request for an appeal. After a final decision is rendered by the *Plan Manager*, the *covered person* has a right to request an External Review in accordance with the procedures outlined in this SPD. During the appeal process, the *covered person* shall have the right, at the *covered person's* own expense, to continue to take any drug prescribed by his or her physician that is the subject of the Advanced Control Formulary changes.

COVERAGE DENIALS

If the *covered person* is not satisfied with the decision of the Internal Appeal of a coverage denial, the *covered person*, authorized person, or provider may request a review of the coverage denial by the Kentucky Department of Insurance (KDOI). The request for a review of the coverage denial must be sent to:

Kentucky Department of Insurance
Health and Life Division
Attn: Coverage Denial Coordinator
P. O. Box 517
Frankfort, KY 40602

The request must be in writing, and should include copies of both the initial denial letter and the Internal Appeal determination letter.

The *Plan Manager* will provide the KDOI with the *necessary information* sufficient to permit the KDOI to make a decision regarding the coverage denial. The *covered person*, authorized person, or provider must also provide the KDOI any information requested that is germane to its review.

The KDOI will determine whether the *service*, treatment, drug, or device is specifically limited or excluded under the terms of the covered person's plan. The KDOI may either overturn or uphold the decision of the Internal Appeal or they may allow an External Review by an *Independent Review Entity (IRE)* if a medical issue requires resolution.

If the KDOI determines that the treatment, *service*, drug, or device is not specifically limited or excluded under the terms of the *covered person's* plan, the Plan will either cover the *service*, treatment, drug, or device, or the Plan will afford the *covered person* an opportunity for External Review. If the KDOI determines that the treatment, *service*, drug, or device is specifically limited or excluded by the Plan, the Plan is not required to cover the treatment, *service*, drug, or device and the *covered person* is not entitled to an External Review.

EXTERNAL REVIEW

***Your* right to External Review:** A *covered person*, an authorized person, or a provider acting on behalf of and with the consent of the *covered person*, may request an External Review of an Adverse Determination

and, in some instances, a coverage denial, rendered by the *Plan Manager*. The Plan will provide for an External Review if:

- The *Plan Manager* has rendered an Adverse Determination or the KDOI has determined that a coverage denial requires a *Medical Necessity* determination;
- The *covered person* has completed the Plan's Internal Appeal process or the *Plan Manager* has failed to make a timely final determination during the Internal Appeal process. The Plan may waive the Internal Appeal process if the Plan and the *covered person* agree to do so; and
- The *covered person* was enrolled in the Plan on the date of service or, if a pre-claim denial, the *covered person* was enrolled and eligible to receive covered benefits under the Plan on the date the proposed *service* was requested.

External Review of an Adverse Determination or Coverage Denial: The *Plan Manager* must receive the request for an External Review within 120 calendar days after the covered person receives a notice of the final Adverse Determination rendered after the Internal Appeal process is complete or within 120 calendar days of a determination by the KDOI that a coverage denial requires a *Medical Necessity* determination.

If someone requests the external review on behalf of the *covered person*, the *covered person* must give them written permission to act on his or her behalf. This permission must be sent to the *Plan Manager*. The *covered person* must also provide the *Plan Manager* with written permission to release his or her medical records to the *IRE* that will conduct the External Review. The release must be sufficient to allow the *IRE* to obtain all necessary medical records from both the Plan, the *Plan Manager*, and any provider utilized for review purposes regarding the decision to deny, limit, reduce or terminate coverage.

An External Review decision will be issued within twenty-one (21) calendar days of the *IRE*'s receipt of all information from the *Plan Manager*. An extension of up to fourteen (14) calendar days may be allowed if the *covered person* and the *Plan Manager* agree to the extension. The *covered person* will be assessed a one (1) time filing fee of twenty-five dollars ($25) to be paid to the *IRE*. The *IRE* will bill the *covered person* for this amount. The fee may be waived if the *IRE* determines that the fee creates a financial hardship on the *covered person*. The fee shall be refunded if the *IRE* finds in favor of the *covered person*. The Plan will pay any remaining costs associated with the External Review.

The decision of the *IRE* shall be binding on the Plan and the *Plan Manager* with respect to that covered person.

Expedited External Review: If the *covered person's* physician believes that waiting for a standard external review decision will seriously jeopardize the *covered person's* health, the *covered person*, an authorized person, or the provider can request an expedited External Review. An expedited External Review is deemed necessary when a *covered person* is hospitalized or, in the opinion of the treating provider, review under the normal timeframe could, in the absence of immediate treatment, result in any of the following:

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

An expedited External Review may be requested orally followed by a brief written request. To initiate an expedited External Review, the *covered person*, authorized person, or provider must call the phone number for the *Plan Manager* provided on the health insurance identification card. Written requests for an External Review must be submitted to:

CVS/Caremark
Attn: Appeals
MC 109
PO Box 52084
Phoenix, AZ 85072-2084

The *Plan Manager* will forward requests for an expedited External Review to the *IRE* within twenty-four (24) hours of receipt of the request by the *Plan Manager*. The *Plan Manager* will request assignment of an *IRE* and submit all required information to the *IRE* for External Review. The *Plan Manager* will provide notice to the *IRE* and to the covered person, by same-day communication, that the Adverse Determination has been assigned to an *IRE* for expedited review.

Expedited External Review decisions will be issued by the *IRE* within twenty-four (24) hours of the *IRE*'s receipt of all information required from the *Plan Manager*. An extension of up to twenty-four (24) hours may be allowed if the covered person and the *Plan Manager* agree to the extension.

The *covered person* will be assessed a one (1) time filing fee of twenty-five dollars ($25) to be paid to the *IRE*. The *IRE* will bill *you* for this amount. The fee may be waived if the *IRE* determines that the fee creates a financial hardship on the *covered person*. The fee shall be refunded if the *IRE* finds in favor of the *covered person*. The Plan will pay any remaining costs associated with the External Review.

The decision of the *IRE* shall be binding on the Plan and the *Plan Manager* with respect to that covered person.

KEHP PRESCRIPTION DRUG COVERAGE AND MEDICARE

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

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

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

2. *KEHP* has determined that the prescription drug coverage offered by *KEHP* is, on average for all plan participants, expected to pay out as much as standard *Medicare* prescription drug coverage pays and is therefore considered Creditable Coverage. Because *your* existing coverage is

Creditable Coverage, *you* can keep this coverage and not pay a higher premium (a penalty) if *you* later decide to join a *Medicare* drug plan.

Questions and Answers about *your* Prescription Drug Coverage and Medicare:

When Can *You* Join A Medicare Drug Plan? *You* can join a *Medicare* drug plan when *you* first become eligible for *Medicare* and each year from October 15th to December 7th.
However, if *you* lose *your* current creditable prescription drug coverage, through no fault of *your* own, *you* will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a *Medicare* drug plan.

What Happens To *Your* Current Coverage If *You* Decide to Join A Medicare Drug Plan? If *you* decide to join a *Medicare* drug plan, *your* current *KEHP* coverage will not be affected. If *you* decide to join a *Medicare* drug plan and drop *your* current *KEHP* coverage, be aware that *you* and *your* dependents may not be able to get this coverage back.

When Will *You* Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan? *You* should also know that if *you* drop or lose *your* current coverage with *KEHP* and don't join a *Medicare* drug plan within 63 continuous days after *your* current coverage ends, *you* may pay a higher premium (a penalty) to join a *Medicare* drug plan later.

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

For More Information About This Notice Or *Your* Current Prescription Drug Coverage…
Contact *KEHP* at the number listed below for further information. **NOTE:** *You*'ll get this notice each year. *You* will also get it before the next period *you* can join a *Medicare* drug plan, and if this coverage through *KEHP* changes. This notice is available at kehp.ky.gov. *You* also may request a copy of this notice at any time.

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

For more information about *Medicare* prescription drug coverage:

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

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

To view a complete copy of the Prescription Drug Coverage and *Medicare* notice with plan comparison information, visit kehp.ky.gov.

Contact Information:

Name of Entity/Sender:	Kentucky Employees' Health Plan
Contact—Position/Office:	Personnel Cabinet, Department of Employee Insurance
Address:	501 High Street, 2nd Floor Frankfort, KY 40601
Phone Number:	888-581-8834 or (502) 564-6534

DEFINITIONS

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

Bodily injury means 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*.

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

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

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

Coinsurance means the percentage of an *eligible expense* that must be paid by the *covered person*. *Coinsurance* does not include *deductibles* or non-*covered expense*s incurred during the *plan year*.

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

Covered expense (or Covered services) means *medically necessary services* incurred by *you* or *your* covered *dependents* for which benefits may be available under this *Plan*, subject to any *maximum benefit* and all other terms, provisions, limitations and exclusions of this *Plan*. A charge for a *covered expense* shall be considered to have been incurred on the date the *service* or supply was provided.

Covered person means the *member* (*employee*, *retiree*, COBRA participant) and his/her covered *dependents* enrolled for benefits provided under this *Plan*.

Creditable coverage, for the purposes of this SPD governing *prescription* coverage, means *prescription* drug coverage where the actuarial value of the coverage equals or exceeds the actuarial value of defined standard *prescription* drug coverage as demonstrated through the use of generally accepted actuarial principles and in accordance with the Centers for Medicare & Medicaid Services' actuarial guidelines, including coverage under a group health plan if it meets the definition of *creditable coverage*.

Deductible means a specified dollar amount of *covered services* that must be satisfied, either individually or combined as a covered family, per *plan year* before this *Plan* pays benefits for certain specified *services*.

Dependent means the following:

1. Spouse –a person to whom *you* are legally married.

2. Common Law Spouse - a person 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– up to 26

   a. An employee's son, daughter, stepson, or stepdaughter;

   b. An employee's eligible foster child. An eligible foster child means an individual who is placed with an employee by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction and includes court awards of guardianship or custody; or

   c. An employee's adopted child. An adopted child means the employee's legally adopted child or a child who is lawfully placed with the *employee* for legal adoption by the *employee*.

4. 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 to be total and permanent. 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.

   A dependent child who is not already covered under the Plan at the time of his/her 26th birthday may not later be enrolled in the Plan on grounds of total and permanent disability unless and until he/she sustains a loss of other insurance coverage. In such a case, a request to enroll a Dependent child in *KEHP* on grounds of total and permanent disability must be made no later than 35 calendar days following the loss of other insurance coverage. Once a Dependent child is approved for coverage in the Plan on grounds of total and permanent disability, the *employee* may periodically be required to produce written or other proof of the continuing nature(s) of the child's dependency and/or disability in order to maintain the child's coverage through the Plan.

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

Dispense as Written (DAW) 1 – *a KEHP design that applies a cost penalty when a non-generic brand medication is dispensed by request (per the doctor), rather than available generic equivalents. An exceptions process is available.*

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 *Plan Manager* for a *participating provider*.

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 the Group Plan or any subsidiary(s).

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

CVS/Caremark Specialty Pharmacy – a specialty *pharmacy* management program specializing in the provision of high-cost biotech and other specialty drugs used to treat long-term chronic disease states and complex conditions.

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

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

Independent Review Entity (IRE) means an individual or organization certified by the KDOI to perform external reviews under KRS 304.17A-623, 304.17A-625, and 304.17A-627.

In-network means *services* provided by *participating pharmacy*.

Kentucky Employees' Health Plan* or *KEHP means the group health plan 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*. *KEHP* may also be referred to as the Public Employee Health Insurance Program.

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

Low-protein modified food means a product formulated to have less than one (1) gram of protein per serving and intended for the dietary treatment of inborn errors of metabolism or genetic conditions under the direction of a physician.

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

1. Generally prescribed for treatment of long-term chronic *sickness* or *bodily injuries*; and

2. Purchased from the *pharmacy* contracted by the *Plan Manager* to dispense drugs.

Medically Necessary or Medical Necessity means health care services that a provider would render to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or its symptoms in a manner that is:

1. In accordance with generally accepted standards of medical practice; and

2. Clinically appropriate in terms of type, frequency, extent, and duration.

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*.

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

Necessary Information means:

1. The results of any face-to-face clinical evaluation;

2. Any second opinion that may be required; and

3. Any other information determined to be necessary to making a utilization review determination.

Non-participating pharmacy means a *pharmacy* that has not entered into an agreement with the *Plan Manager* to provide *participating provider* services as part of *Plan Manager's* Pharmacy Network or has not been designated by the *Plan Manager* as a *participating provider*.

Opioid Management *– means stricter quantity limits on opioid medications to help prevent misuse, overuse, and abuse, based on CDC guidelines.*

Out-of-Network means services provided by a *non-participating pharmacy*.

Over-the-Counter (OTC) drug – a drug product that does not require a *prescription* order under federal or state law.

Participating pharmacy means a *pharmacy* that has entered into an agreement with, or has been designated by, the *Plan Manager* to participate as part of the *Plan Manager's* Pharmacy Network to dispense covered drugs to *covered persons* and to accept as payment, the *coinsurance* amount to be paid by *you* and the amount of the benefit payment provided by the Plan.

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

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

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

Plan year means a period of time beginning on the Plan anniversary date of any year and ending on the day before the same date of the succeeding year. *KEHP's plan year* is based on a *calendar year*.

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 order 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, address and DEA number of the *qualified practitioner*.

Prior authorization (PA) means the process of obtaining certification of coverage for certain *prescription* drug products, prior to their dispensing.

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

1. Provides for support of a covered *employee's* child;

2. Provides for health benefit coverage to the child;

3. Is made under state domestic relations law;

4. Relates to benefits under this Plan; and

5. Is qualified in that it meets the technical requirements of ERISA or applicable state law.

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

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.

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

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

Services mean procedures, surgeries, exams, consultations, advice, diagnosis, referrals, treatment, tests, supplies, drugs, medications, 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.

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

Therapeutic food, formulas, and supplements means products intended for the dietary treatment of inborn errors of metabolism or genetic conditions, including but not limited to eosinophilic disorders, food protein allergies, food protein-induced enterocolitis syndrome, mitochondrial disease, and short bowel disorders,

under the direction of a physician, and includes amino acid-based elemental formula and the use of vitamin and nutritional supplements such as coenzyme Q10, vitamin E, vitamin C, vitamin B1, vitamin B2, vitamin K1, and L-carnitine;

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

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

TRICARE means the name of the federal government's managed health care program for active-duty military, active-duty service families, retirees and their families, and other beneficiaries. An individual who is ordered to active duty for more than 30 days is automatically enrolled in TRICARE (TRICARE Prime a HMO-type option) and the individual's dependents are also eligible to receive benefits under TRICARE

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

Utilization Review - means a review of the *medical necessity* and appropriateness of hospital resources and medical *services* given or proposed to be given to a covered person for purposes of determining the availability of payment. Utilization review includes concurrent review, pre-claim review, and post-claim review.

You and your means *you* as the *employee* and any of *your* covered *dependents*, unless otherwise indicated.

Value Formulary – a high-value formulary that promotes the utilization of generic medicines, when appropriate, and covers medicines that treat all health conditions that are covered by the plan.