



Humana

**KENTUCKY EMPLOYEES'
HEALTH PLAN**

SUMMARY PLAN DESCRIPTION

For the

**LIVINGWELL PPO
MEDICAL PLAN**

Sponsored by

Commonwealth of Kentucky

Group Number(s): P5941, P6070 and P6077

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

Effective: January 1, 2014

NOTICE OF AVAILABILITY OF SUMMARY OF BENEFITS AND COVERAGE (SBC)

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

YOUR RIGHTS AND RESPONSIBILITIES

<p>As a Humana <i>plan member</i>, you have the right to:</p> <ul style="list-style-type: none"> • Be provided with information about the Humana <i>plan</i>, its <i>services</i> and benefits, its <i>providers</i>, and <i>your member</i> rights and responsibilities. • Privacy and confidentiality regarding <i>your</i> medical care and records. Records pertaining to <i>your</i> health care will not be released without <i>your</i> or <i>your</i> authorized representative's written permission, except as required by law. • Discuss <i>your</i> medical record with <i>your physician</i>, and receive upon request a copy of that record. • Be informed of <i>your</i> diagnosis, treatment choices, including non-treatment, and prognosis in terms <i>you</i> can reasonably expect to understand, and to participate in decision-making about <i>your</i> health care and treatment plan. • Have a candid discussion with <i>your</i> practitioner about appropriate or <i>medically necessary</i> treatment options for <i>your</i> conditions, regardless of cost or benefit coverage. • Expect reasonable access to <i>medically necessary</i> health care <i>services</i> regardless of race, national origin, religion, physical abilities, or source of payment. • File a formal complaint, as outlined in the <i>plan's</i> grievance procedure, and to expect a response to that complaint within a reasonable period of time. • Be treated with courtesy and respect, with appreciation for <i>your</i> dignity and protection of <i>your</i> right to privacy. • Make recommendations regarding the <i>Plan's</i> "rights and responsibilities" policies. 	<p>You also have the responsibility to:</p> <ul style="list-style-type: none"> • Give the Humana <i>Plan</i> and <i>your</i> health care <i>provider</i> complete and accurate information needed in order to care for <i>you</i>. • Read and be aware of all material distributed by the <i>plan</i> explaining policies and procedures regarding <i>services</i> and benefits. • Obtain and carefully consider all information <i>you</i> may need or desire in order to give informed consent for a procedure or treatment. • Follow the treatment plan agreed on with <i>your</i> health care <i>provider</i>, and to weigh the potential consequences of any refusal to observe those instructions or recommendations. • Be considerate and cooperative in dealing with the <i>plan providers</i> and to respect the rights of fellow <i>plan members</i>. • Schedule appointments, arrive on time for scheduled visits, and notify <i>your</i> health care <i>provider</i> if <i>you</i> must cancel or be late for a scheduled appointment. • Express opinions, concerns, or complaints in a constructive manner. • Notify the <i>Plan Sponsor</i> (Commonwealth of Kentucky) in writing if <i>you</i> move or change <i>your</i> address or phone number, even if these changes are only temporary. • Pay all <i>copayments</i>, <i>coinsurance</i> and/or <i>premiums</i> by the date when they are due. • Be honest and open with <i>your physician</i> and report unexpected changes in <i>your</i> condition in a timely fashion. • Follow health care facility rules and regulations affecting patient care and conduct.
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As a Humana *plan member*, you have the right to:

- Receive Humana’s Notice of Privacy Practices.
- Expect *your* personal information to be kept secure and used appropriately for payment and health plan operations.
- Expect Humana to adhere to all privacy and confidentiality policies and procedures.
- Expect the following activities concerning *your* personal information:
 - Request an accounting of disclosures of personal health information disclosed for reasons outside of payment and health plan operations.
 - Receive an authorization form for any proposed use of *your* personal health information outside of routine payment and health plan operations.
 - Request an alternate form of communication of personal health information if the release of a portion or all of the information could endanger life or health.
 - Right to complain regarding an alleged breach of privacy.
 - Right to agree or object regarding Humana’s intent to release *your* personal information outside of payment or health plan operations.
 - Right to request an amendment or correction of *your* personal information to a designated record created by Humana.
 - Right to request access to inspect and copy information.

You also have the responsibility to:

- Carry *your* Humana identification card with *you* at all times and use it while enrolled in the Humana *Plan*.

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

- Expect the following activities concerning *your* personal information continued:
 - Right to request Humana to restrict the use and disclosure of *your* personal information and the right to terminate the restriction request.



Humana

INTRODUCTION

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

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

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

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

DEFINED TERMS

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

PRIVACY

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

CONTACT INFORMATION

Customer Service Telephone Number:

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

Claims Submittal Address:

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

Claims Appeal Address:

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

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SECTION 1

HEALTH RESOURCES AND PRECERTIFICATION

HEALTH RESOURCES

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

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

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

UTILIZATION MANAGEMENT

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

Precertification and Concurrent Review

Utilization review may include *precertification* and *concurrent review*.

Precertification for *emergency services* is not required.

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

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

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

1. Advise *you* by telephone, electronically, or in writing if the proposed treatment plan is *medically necessary*; and
2. Conduct *concurrent review* as necessary.

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

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

Penalty for Not Obtaining Precertification

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

CASE MANAGEMENT

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

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

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

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

TRANSITION OF CARE

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

CONTINUITY OF CARE

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

HUMANA HEALTH ALERTS

PREVENTIVE REMINDERS

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

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

GAPS IN CARE

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

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

When gaps in care, drug to drug interaction, drug to disease interaction or a preventive reminder is identified, an alert and a message, if appropriate, are generated to communicate the findings through physician and member messaging.

NEONATAL INTENSIVE CARE UNIT (NICU) MANAGEMENT

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

The Neonatal Case Management program includes:

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

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

TRANSPLANT MANAGEMENT

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

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

BARIATRIC MANAGEMENT

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

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

MYHUMANA

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

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

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

CONDITION MANAGEMENT

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

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

DISEASE MANAGEMENT

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

This Plan’s disease management programs include:

- **Asthma:** This program provides participants with education to help them better understand their disease and to take a more active role in controlling it. The program helps participants adhere to the treatment plan prescribed by their physician, helps them increase their self-monitoring skills and promotes compliance with controller medications.
- **Cancer (active treatment only):** The cancer management program offers support and educational services to adults with cancer who have begun or are planning to undergo *surgery*, chemotherapy, radiation therapy or biological therapy, those that have a history of cancer that has recurred and those that have declined further therapy but require supportive management. The program’s oncology care managers have an average of 10 years of professional experience in understanding cancer, its symptoms, side effects and treatments.

HEALTH RESOURCES (continued)

- **Chronic Obstructive Pulmonary Disease:** This program focuses on adherence to physicians' treatment plan, as well as education and goal development. Main focus areas include smoking cessation, diet and exercise, and lung health. Ongoing clinician support also discusses symptoms and warning signs education.
- **Congestive Heart Failure:** This program focuses on those with moderate to severe heart failure and is delivered primarily through clinicians who assist participants through a combination of intervention, monitoring and education.
- **Coronary Artery Disease:** This program helps participants adhere to their physicians' prescription and treatment plan, monitor their health status for complications and decrease cardiovascular risks. Ongoing guidance and education is provided, focusing on clinical and behavioral issues such as high blood pressure, elevated lipid levels, smoking and lack of exercise.
- **Diabetes:** This program provides ongoing education about disease management and monitoring in the areas of diet, exercise and lifestyle. Clinicians who have received additional training in diabetes disease management are available to answer questions.
- **End Stage Renal Disease (ESRD):** The end-stage renal disease program provides support designed to address quality-of-life issues of those with ESRD and late-stage Chronic Kidney Disease. ESRD staff work closely with participants, local nephrologists and dialysis centers to coordinate services and monitor medical management.
- **Rare Diseases (Amyotrophic Lateral Sclerosis, or Lou Gehrig's Disease; Chronic Inflammatory Demyelinating Polyradiculoneuropathy Disease (CIDP); Cystic Fibrosis; Dermatomyositis; Hemophilia; Multiple Sclerosis; Myasthenia Gravis; Parkinson's Disease; Polymyositis; Rheumatoid Arthritis; Scleroderma; Sickle Cell Disease; and Systemic Lupus):** Participants receive information tailored to their individual situation. Each program addresses the individual's medical, educational and psychological needs by providing disease-specific online tools and resources, service coordination and education via telephone contact and access to specially trained clinicians.

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

PERSONAL NURSE®

In addition to disease-specific programs, Humana also offers Personal Nurse, which supports members with long-term, ongoing health needs and/or any chronic condition. Personal Nurses offers *covered persons* dealing with a condition or illness, following treatment plans, or needing continued guidance in reaching their long-term health goals, the opportunity to develop a long-term partnership with an experienced registered nurse. Personal Nurses provide both personalized education and guidance to resources to help participants better understand their condition or illness and effectively use their benefits. They also teach the benefits of wellness, prevention and disease avoidance, help identify roadblocks to improved health, motivate and support participants' efforts to meet goals and refer participants to other Health Resource programs that may meet their needs.

HEALTH RESOURCES (continued)

Participants will speak with the same Personal Nurse every time – whether the call is initiated by the nurse or the *covered person*. Personal Nurses work flexible hours and will provide participants with their direct telephone number. Participants can stay with their Personal Nurse for as long as they remain a member of this Plan.

HUMANABEGINNINGS®

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

Humana*Beginnings*® includes:

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

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

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

- Online at MyHumana (www.myhumana.com); or
- Calling toll-free 1-888-847-9960.

HUMANAFIRST® NURSE ADVICE LINE

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

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

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

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

ONCOLOGY QUALITY MANAGEMENT

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

RADIATION THERAPY MANAGEMENT

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

- *Covered persons* can have their radiation therapy performed at any facility that their oncologist directs them to (if *you* see a *PAR provider*, *covered expenses* will be paid under the *PAR Provider* benefit, if *you* see a *Non-PAR provider*, *covered expenses* will be paid under the *Non-PAR provider* benefit);
- Physician-to-physician: Clinical appropriateness evaluation and consultation;
- Radiation Therapy Management: lowers long term costs by improving outcomes through a reduction of:
 - Recurring cancers, which can result from ineffective radiation delivery;
 - Secondary cancers caused by unnecessary radiation exposure to healthy tissue;
 - Side effects, which can require additional treatment.

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

HEALTH RESOURCES

RADIOLOGY REVIEW SERVICES

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

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

HUMANAVITALITY PROGRAM

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

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

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

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

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

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

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

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

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

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

PRECERTIFICATION

TELEPHONIC AND ONLINE HEALTH COACHING

To enroll in the Telephonic Health Coaching and Online Program, log in to *MyHumana* at www.humana.com.

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

HumanaVitality[®] Summary

INTRODUCTION

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

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

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

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

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

For additional information, please contact HumanaVitality[®] at 1-877-597-7474.

PRECERTIFICATION

Humana will provide *precertification* as required by this Plan. It is recommended that you or your provider call 877-597-7474 as soon as possible to receive proper precertification.

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

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

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

TRANSPLANTS

Humana must be notified prior to receiving transplant *services*.

DURABLE MEDICAL EQUIPMENT (DME) AND PROSTHETICS

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

MORBID OBESITY - BARIATRIC SURGERY

Humana must be notified prior to receiving *bariatric surgery*.

HOME HEALTH CARE, HOME INFUSION AND HOME HOSPICE

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

GENETIC MOLECULAR TESTING

Humana must be notified prior to receiving genetic molecular testing.

PHARMACY

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

CHEMOTHERAPY AGENTS, SYMPTOM MANAGEMENT DRUGS AND SUPPORTIVE DRUGS

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

The *precertification* penalty does not apply to these services.

PRECERTIFICATION (continued)

RADIATION THERAPY

Humana must be notified prior to receiving radiation therapy.

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

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

INPATIENT BEHAVIORAL HEALTH (INCLUDING ACUTE CARE AND PARTIAL HOSPITALIZATION)

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

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

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

PRECERTIFICATION PENALTY FOR TRANSPLANT SERVICES

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

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

Penalties do not apply to *emergency services*.

PRECERTIFICATION PENALTY FOR ALL OTHER SERVICES

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

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

Penalties do not apply to *emergency services*.

PREDETERMINATION OF BENEFITS

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

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

SECTION 2

MEDICAL BENEFITS

UNDERSTANDING YOUR COVERAGE

PARTICIPATING AND NON-PARTICIPATING PROVIDERS

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

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

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

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

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

HUMANA/CHOICECARE PPO PAR PROVIDER DIRECTORY

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

COVERED AND NON-COVERED EXPENSES

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

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

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

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

SCHEDULE OF BENEFITS

IMPORTANT INFORMATION ABOUT PLAN BENEFITS

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

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

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

DEDUCTIBLES, COINSURANCE, OUT-OF-POCKET LIMITS, LIFETIME MAXIMUM BENEFIT AND OFFICE VISIT COPAYMENTS		
BENEFIT FEATURES	PAR PROVIDER BENEFIT (IN-NETWORK)	NON-PAR PROVIDER BENEFIT (OUT-OF-NETWORK)
Individual <i>Deductible</i>	\$500 per covered person	\$1,000 per covered person
Family <i>Deductible</i>	\$1,000 (embedded) per covered family	\$2,000 (embedded) per covered family
<p>If you have more than one family member covered under <i>your</i> plan, one family member may satisfy the individual \$500 <i>deductible</i> and the remaining \$500 family <i>deductible</i> may be met by any combination of the remaining family member’s <i>claims</i> up to the \$1,000 family <i>deductible</i> maximum. Here are the <i>deductible</i> rules:</p> <ul style="list-style-type: none"> • No single family member will pay more than \$500 in <i>deductible</i>; • No single family member can contribute more than \$500 to the family <i>deductible</i> maximum; and • Of the \$1,000 family maximum <i>deductible</i>, \$500 can be met by a family member and the remaining \$500 can be met by a combination of additional family members; or • All family members’ <i>services</i> can be combined and applied to meet the family \$1,000 <i>deductible</i>. • If only two family <i>members</i> are covered under this <i>Plan</i> (<i>employee</i> and spouse or <i>employee</i> and one child), each covered <i>member</i> will have a \$500 <i>deductible</i>. You will not have to satisfy the family <i>deductible</i>. 		
<i>Coinsurance</i>	The <i>Plan</i> pays 80%, you pay 20%.	The <i>Plan</i> pays 60%, you pay 40%.
Individual <i>Out-of-Pocket Limit</i> (Includes <i>Deductible</i>)	\$2,500 per covered person	\$5,000 per covered person

SCHEDULE OF BENEFITS (continued)

DEDUCTIBLES, COINSURANCE, OUT-OF-POCKET LIMITS, LIFETIME MAXIMUM BENEFIT AND OFFICE VISIT COPAYMENTS		
BENEFIT FEATURES	PAR PROVIDER BENEFIT (IN-NETWORK)	NON-PAR PROVIDER BENEFIT (OUT-OF-NETWORK)
Family <i>Out-of-Pocket Limit</i> (Includes <i>Deductible</i>)	\$5,000 per covered family	\$10,000 per covered family
<p>When the amount of combined <i>covered expenses</i> paid by <i>you</i> and/or all <i>your</i> covered <i>dependents</i> satisfy the <i>out-of-pocket limits</i>, including the <i>deductible</i> as shown on the Schedule of Benefits, the <i>Plan</i> will pay 100% of <i>covered expenses</i> for the remainder of the <i>calendar year</i>, unless specifically indicated, subject to any <i>calendar year</i> maximums of the <i>Plan</i>. All <i>copayments</i> apply to the maximum out-of-pocket except prescription <i>copayments</i>.</p> <p>If only two family <i>members</i> are covered under this <i>Plan</i> (<i>employee</i> and spouse or <i>employee</i> and one child), each covered <i>member</i> will satisfy the individual out-of-pocket limit. <i>You</i> will not have to satisfy the family <i>out-of-pocket limit</i>.</p> <p>If <i>you</i> and <i>your</i> covered <i>dependents</i> use a combination of <i>PAR</i> and <i>Non-PAR providers</i>, the <i>PAR</i> and <i>Non-PAR deductible</i> amounts will accumulate separately and do not cross apply.</p> <p>If <i>you</i> and <i>your</i> covered <i>dependents</i> use a combination of <i>PAR</i> and <i>Non-PAR providers</i>, the <i>PAR</i> and <i>Non-PAR out-of-pocket</i> amounts will accumulate separately and do not cross apply.</p> <p>If <i>you</i> or <i>your</i> covered <i>dependents</i> use a <i>Non-PAR provider</i>, the <i>Plan Manager's</i> (Humana) reimbursement will be payable on a <i>maximum allowable fee</i> basis. Any amounts above the <i>maximum allowable fee</i> will be the <i>member's</i> responsibility and will NOT apply to the <i>out-of-pocket limit</i>.</p>		
Lifetime Maximum Benefit	Unlimited	Unlimited
<i>Qualified Practitioner Primary Care Physician (PCP) Office Visit Copayment</i>	\$25	Not applicable
<i>Qualified Practitioner Specialist Office Visit Copayment</i>	\$45	Not applicable

SCHEDULE OF BENEFITS (continued)

**DEDUCTIBLES, COINSURANCE, OUT-OF-POCKET LIMITS,
LIFETIME MAXIMUM BENEFIT AND OFFICE VISIT COPAYMENTS**

BENEFIT FEATURES	PAR PROVIDER BENEFIT (IN-NETWORK)	NON-PAR PROVIDER BENEFIT (OUT-OF-NETWORK)
<p><i>Primary Care Physician (PCP)</i> is defined as a family practice physician, pediatrician, doctor of internal medicine, general practitioner, OBGYN, chiropractor, nurse practitioner, <i>physician assistant</i>, registered nurse, optometrist and retail / minute clinic. A specialist (including specialty nurse practitioner, specialty RN's and specialty PA's) would be all other <i>qualified practitioners</i>.</p> <p>One <i>copayment</i> will be taken per day (same day and same site as office visit) per servicing <i>provider</i>, unless otherwise indicated in this Schedule.</p>		

**ROUTINE/PREVENTIVE CHILD CARE SERVICES
BIRTH TO AGE 18
(Services Received at a Clinic or Outpatient Hospital)**

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

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

SCHEDULE OF BENEFITS (continued)

<p align="center">ROUTINE/PREVENTIVE CHILD CARE SERVICES BIRTH TO AGE 18 (Services Received at a Clinic or Outpatient Hospital)</p>		
MEDICAL SERVICES	PAR PROVIDER BENEFIT (IN-NETWORK)	NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)
<i>Childhood Obesity</i> Nutritional Counseling with a Nutritionist or Dietician who is a Registered Dietician (children between the ages of 3 and 18 only)	Payable at 100%	60% after <i>deductible</i>
<i>Childhood Obesity</i> Examinations/Nutritional Counseling Limits	8 visits per eligible covered <i>dependent</i> child per <i>calendar year</i>	
Routine/Preventive Child Care Laboratory	Payable at 100%	60% after <i>deductible</i>
Routine/Preventive Child Care X-ray	Payable at 100%	60% after <i>deductible</i>
Routine/Preventive Child Care Immunizations	Payable at 100%	60% after <i>deductible</i>
Routine/Preventive Child Care Immunizations (e.g. HPV Vaccine, Meningitis Vaccine, etc.) Immunizations are covered based on the recommendations by the Department of Health and Human Services - Centers for Disease Control and Prevention	Payable at 100%	60% after <i>deductible</i>

SCHEDULE OF BENEFITS (continued)

**ROUTINE/PREVENTIVE CHILD CARE SERVICES
BIRTH TO AGE 18**

(Services Received at a Clinic or Outpatient Hospital)

MEDICAL SERVICES	PAR PROVIDER BENEFIT (IN-NETWORK)	NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)
Routine/Preventive Child Care Flu/Pneumonia Immunizations	Payable at 100%	60% after <i>deductible</i>

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

**ROUTINE/PREVENTIVE ADULT CARE SERVICES
AGE 18 AND OVER**

(Services Received at a Clinic or Outpatient Hospital)

MEDICAL SERVICES	PAR PROVIDER BENEFIT (IN-NETWORK)	NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)
Routine/Preventive Adult Care Examination (including routine vision and hearing screening when part of a <i>qualified practitioner primary care physician</i> examination)	Payable at 100%	60% after <i>deductible</i>
Routine/Preventive Adult Care Laboratory	Payable at 100%	60% after <i>deductible</i>
Routine/Preventive Adult Care X-ray	Payable at 100%	60% after <i>deductible</i>

SCHEDULE OF BENEFITS (continued)

<p align="center">ROUTINE/PREVENTIVE ADULT CARE SERVICES AGE 18 AND OVER (Services Received at a Clinic or Outpatient Hospital)</p>		
<p align="center">MEDICAL SERVICES</p>	<p align="center">PAR PROVIDER BENEFIT (IN-NETWORK)</p>	<p align="center">NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)</p>
<p>Routine/Preventive Adult Care Immunizations (e.g. Shingles Vaccine, Meningitis Vaccine, HPV Vaccine, etc.)</p> <p>Immunizations are covered based on the recommendations by the Department of Health and Human Services - Centers for Disease Control and Prevention</p>	<p>Payable at 100%</p>	<p>60% after <i>deductible</i></p>
<p>Routine/Preventive Adult Care Flu/Pneumonia Immunizations</p>	<p>Payable at 100%</p>	<p>60% after <i>deductible</i></p>
<p>Routine/Preventive Adult Care Mammograms</p>	<p>Payable at 100%</p>	<p>60% after <i>deductible</i></p>
<p>Routine/Preventive Adult Care Pap Smears</p>	<p>Payable at 100%</p>	<p>60% after <i>deductible</i></p>

SCHEDULE OF BENEFITS (continued)

<p align="center">ROUTINE/PREVENTIVE ADULT CARE SERVICES AGE 18 AND OVER (Services Received at a Clinic or Outpatient Hospital)</p>		
<p align="center">MEDICAL SERVICES</p>	<p align="center">PAR PROVIDER BENEFIT (IN-NETWORK)</p>	<p align="center">NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)</p>
<p>Routine/Preventive Adult Care Colonoscopy, Proctosigmoidoscopy and Sigmoidoscopy Screenings (including related <i>services</i>) (performed at an <i>outpatient</i> facility, <i>ambulatory surgical center</i> or clinic location). Removal of polyps during a routine colonoscopy will be payable as a preventive procedure.</p>	<p>Payable at 100%</p>	<p>60% after <i>deductible</i></p>
<p>Prostate Specific Antigen (PSA) Testing</p>	<p>Payable at 100%</p>	<p>60% after <i>deductible</i></p>
<p>Physical Examination Yearly Visit Limits</p>	<p>1 visit per <i>covered person</i></p>	
<p>Well Woman Examination Yearly Visit Limits</p>	<p>1 visit per <i>covered person</i></p>	
<p>Sometimes during the course of a screening procedure (routine wellness or preventive care), abnormalities or problems may be identified that require immediate intervention or additional diagnosis. If this occurs, and <i>your provider</i> performs additional necessary procedures, the <i>service</i> will be considered diagnostic and/or surgical, rather than screening, depending on the <i>claim</i> for the <i>services</i> submitted by <i>your provider</i>. This may result in a possible difference in <i>your copayment</i> and/or <i>coinsurance</i>.</p>		
<p>Breast Feeding Counseling</p>	<p>Payable at 100%</p>	<p>60% after <i>deductible</i></p>

SCHEDULE OF BENEFITS (continued)

**ROUTINE/PREVENTIVE ADULT CARE SERVICES
AGE 18 AND OVER
(Services Received at a Clinic or Outpatient Hospital)**

MEDICAL SERVICES	PAR PROVIDER BENEFIT (IN-NETWORK)	NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)
Breast Feeding Support and Supplies	Payable at 100%	60% after <i>deductible</i>
<p>Contraceptive Methods - devices (e.g. IUD or diaphragms), injections, implant insertion/removal, Sterilization and tubal ligation</p> <p>For information on <i>prescription</i> drug coverage for birth control pills/patches, abortifacients, spermicide, the morning after pill and condoms, please see <i>your prescription</i> drug benefits.</p>	<p>Payable at 100%</p> <p>If <i>services</i> are not to prevent pregnancy, then they are payable the same as any other <i>sickness</i>.</p>	<p>60% after <i>deductible</i></p> <p>If <i>services</i> are not to prevent pregnancy, then they are payable the same as any other <i>sickness</i>.</p>
<p>Age limits do not apply to routine mammograms and pap smears.</p> <p>To the extent required by the Affordable Care Act, age limits do not apply to breast feeding counseling, breast feeding support and supplies, contraceptive methods and sterilization.</p>		

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

SCHEDULE OF BENEFITS (continued)

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

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

HEARING AIDS AND RELATED SERVICES BIRTH THROUGH AGE 17		
MEDICAL SERVICES	PAR PROVIDER BENEFIT (IN-NETWORK)	NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)
Routine Hearing Examination and Testing	Not Covered	Not Covered
<i>Hearing Aids</i> and Fitting	80% after <i>deductible</i>	60% after <i>deductible</i>
<i>Hearing Aids</i> and Fitting Limits	\$1,400 per <i>covered person</i> through age 17, per hearing impaired ear, once every 36 months.	

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

SCHEDULE OF BENEFITS (continued)

QUALIFIED PRACTITIONER SERVICES (Non-Routine/Non-Preventive Care Services)		
MEDICAL SERVICES	PAR PROVIDER BENEFIT (IN-NETWORK)	NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)
Diagnostic Office Examination at a Clinic, including Second Surgical Opinion – <i>Qualified Practitioner Primary Care Physician</i>	100% after a \$25 <i>copayment</i>	60% after <i>deductible</i>
Diagnostic Office Examination at a Clinic, including Second Surgical Opinion - <i>Qualified Practitioner Specialist</i>	100% after a \$45 <i>copayment</i>	60% after <i>deductible</i>
If an office examination is billed from an <i>outpatient</i> location, the <i>services</i> will be payable the same as an office examination at a clinic.		
Diagnostic Laboratory at a Clinic	Payable at 100%	60% after <i>deductible</i>
Diagnostic X-ray at a Clinic (other than <i>advanced imaging</i>)	Payable at 100%	60% after <i>deductible</i>
Independent Laboratory	Payable at 100%	60% after <i>deductible</i>
<i>Advanced Imaging</i> at a Clinic	Payable at 100%	60% after <i>deductible</i>

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

SCHEDULE OF BENEFITS (continued)

QUALIFIED PRACTITIONER SERVICES (Non-Routine/Non-Preventive Care Services)		
MEDICAL SERVICES	PAR PROVIDER BENEFIT (IN-NETWORK)	NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)
Allergy Testing at a Clinic	100% after the applicable <i>qualified practitioner</i> office visit <i>copayment</i>	60% after <i>deductible</i>
Allergy Serum/Vials at a Clinic	100% after the applicable <i>qualified practitioner</i> office visit <i>copayment</i>	60% after <i>deductible</i>
Allergy Injections at a Clinic	100% after a \$25 <i>copayment</i>	60% after <i>deductible</i>
<i>Copayments for allergy injections are applied per visit (highest copayment will apply).</i>		
Injections at a Clinic (other than routine immunizations, flu or pneumonia injections, contraceptive injections for birth control reasons and allergy injections)	100% after a \$25 <i>copayment</i>	60% after <i>deductible</i>
Anesthesia at a Clinic	100% after the applicable <i>qualified practitioner</i> office visit <i>copayment</i>	60% after <i>deductible</i>
<i>Surgery</i> at a Clinic (including <i>Qualified Practitioner, Assistant Surgeon and Physician Assistant</i>)	100% after the applicable <i>qualified practitioner</i> office visit <i>copayment</i>	60% after <i>deductible</i>
Medical and Surgical Supplies	Payable at 100%	60% after <i>deductible</i>

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

SCHEDULE OF BENEFITS (continued)

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

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

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

SCHEDULE OF BENEFITS (continued)

REVERSAL OF STERILIZATION AND ABORTIONS		
MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
Reversal of Sterilization	Not Covered	Not Covered
Life Threatening Abortions	Payable the same as any other <i>sickness</i> .	Payable the same as any other <i>sickness</i> .
Elective Abortions	Not Covered	Not Covered
Vasectomy	Payable the same as any other <i>sickness</i> .	Payable the same as any other <i>sickness</i> .

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

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

SCHEDULE OF BENEFITS (continued)

MATERNITY (Normal, C-Section and Complications)		
MEDICAL SERVICES	PAR PROVIDER BENEFIT (IN-NETWORK)	NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)
Newborn <i>Inpatient Qualified Practitioner Services</i>	80% after <i>deductible</i>	60% after <i>deductible</i>
Newborn <i>Inpatient Facility Services</i>	80% The newborn <i>deductible</i> and <i>copayment</i> will be waived for <i>facility services</i> .	60% The newborn <i>deductible</i> and <i>copayment</i> will be waived for <i>facility services</i> .

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

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

SCHEDULE OF BENEFITS (continued)

INPATIENT SERVICES		
MEDICAL SERVICES	PAR PROVIDER BENEFIT (IN-NETWORK)	NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)
Private Duty Nursing	Not Covered	Not Covered

SKILLED NURSING SERVICES		
MEDICAL SERVICES	PAR PROVIDER BENEFIT (IN-NETWORK)	NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)
Skilled Nursing Room and Board and Ancillary Facility Services	80% after <i>deductible</i>	60% after <i>deductible</i>
Skilled Nursing Facility Yearly Limits	30 day(s) per <i>covered person</i>	
Skilled Nursing <i>Qualified Practitioner</i> Visit	80% after <i>deductible</i>	60% after <i>deductible</i>

SCHEDULE OF BENEFITS (continued)

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

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

SCHEDULE OF BENEFITS (continued)

OUTPATIENT AND AMBULATORY SURGICAL CENTER SERVICES		
MEDICAL SERVICES	PAR PROVIDER BENEFIT (IN-NETWORK)	NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)
<i>Outpatient Hospital and Ambulatory Surgical Center Qualified Practitioner Visit</i>	80% after <i>deductible</i>	60% after <i>deductible</i>
<i>Outpatient Hospital and Ambulatory Surgical Center Surgery (including surgeon; assistant surgeon; and physician assistant) and Anesthesia</i>	80% after <i>deductible</i>	60% after <i>deductible</i>
<i>Outpatient Hospital and Ambulatory Surgical Center Pathology and Radiology</i>	80% after <i>deductible</i>	60% after <i>deductible</i>

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

EMERGENCY AND URGENT CARE SERVICES		
MEDICAL SERVICES	PAR PROVIDER BENEFIT (IN-NETWORK)	NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)
Emergency Room Facility Services (true <i>emergency</i>) If you are admitted to the <i>hospital</i> , the <i>copayment</i> will be waived.	\$150 <i>copayment</i> then 80% after <i>deductible</i>	Payable the same as <i>PAR Provider Benefit</i> .

SCHEDULE OF BENEFITS (continued)

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

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

SCHEDULE OF BENEFITS (continued)

EMERGENCY AND URGENT CARE SERVICES		
MEDICAL SERVICES	PAR PROVIDER BENEFIT (IN-NETWORK)	NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)
<i>Urgent Care Center (facility, ancillary services and qualified practitioner services)</i>	100% after a \$50 <i>copayment</i>	Payable the same as <i>PAR Provider Benefit</i> .

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

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

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

SCHEDULE OF BENEFITS (continued)

HOME HEALTH CARE SERVICES		
MEDICAL SERVICES	PAR PROVIDER BENEFIT (IN-NETWORK)	NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)
Home Health Care <i>Services</i>	80% after <i>deductible</i>	60% after <i>deductible</i>
Home Health Care Yearly Limits	60 visit(s) per <i>covered person</i>	
<p>Home therapy benefits will be reimbursed under the home health care benefit.</p> <p>If therapies are done in the home (such as physical or occupational therapy), these therapy <i>services</i> will apply to the home health care limits.</p> <p>If therapies and home health visits are done on the same day the <i>services</i> will track as one visit per day.</p>		
Home Health Care Ancillary <i>Services</i> (excluding <i>durable medical equipment</i> , prosthetics and private duty nursing)	80% after <i>deductible</i>	60% after <i>deductible</i>

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

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

SCHEDULE OF BENEFITS (continued)

DURABLE MEDICAL EQUIPMENT (DME)		
MEDICAL SERVICES	PAR PROVIDER BENEFIT (IN-NETWORK)	NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)
Prosthesis (Clinic)	100% after the applicable <i>qualified practitioner</i> office visit <i>copayment</i>	60% after <i>deductible</i>
Prosthesis (<i>Inpatient</i> or <i>Outpatient</i>)	80% after <i>deductible</i>	60% after <i>deductible</i>
Wigs	Not Covered	Not Covered

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

SPECIALTY DRUGS		
MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
<i>Specialty Drugs (Qualified Practitioner's Office Visit, Home Health Care, Freestanding Facility and Urgent Care)</i>	Payable the same as any other <i>sickness</i> .	Payable the same as any other <i>sickness</i> .
<i>Specialty Drugs (Emergency Room, Ambulance, Inpatient Hospital, Outpatient Hospital and Skilled Nursing Facility)</i>	Payable the same as any other <i>sickness</i> .	Payable the same as any other <i>sickness</i> .

SCHEDULE OF BENEFITS (continued)

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

MORBID OBESITY SERVICES		
MEDICAL SERVICES	PAR PROVIDER BENEFIT (IN-NETWORK)	NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)
The following <i>service</i> will be covered under the <i>morbid obesity</i> benefit: examinations/qualified practitioner visits, laboratory and x-ray services and other diagnostic testing, psychological counseling for obesity surgery, bariatric surgery, inpatient facility services, outpatient facility services, home health service, nutritional counseling, and durable medical equipment.		
<i>Morbid Obesity</i>	Payable the same as any other <i>sickness</i> .	Payable the same as any other <i>sickness</i> .

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

SCHEDULE OF BENEFITS (continued)

OBESITY SERVICES		
MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
Obesity	Payable the same as any other <i>sickness</i> .	Payable the same as any other <i>sickness</i> .

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

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

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

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

SCHEDULE OF BENEFITS (continued)

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

THERAPY SERVICES		
MEDICAL SERVICES	PAR PROVIDER BENEFIT (IN-NETWORK)	NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)
Therapy <i>copayments</i> apply to <i>therapy services</i> , regardless of <i>provider</i> specialty (for example, if a Podiatrist is performing physical therapy, the physical therapy <i>copayment</i> will apply).		
Chiropractic Examinations	100% after a \$25 <i>copayment</i>	60% after <i>deductible</i>
Chiropractic Laboratory and X-ray	Payable at 100%	60% after <i>deductible</i>

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

SCHEDULE OF BENEFITS (continued)

THERAPY SERVICES		
MEDICAL SERVICES	PAR PROVIDER BENEFIT (IN-NETWORK)	NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)
Chiropractic Manipulations	100% after a \$25 <i>copayment</i>	60% after <i>deductible</i>
Chiropractic Therapy	100% after a \$25 <i>copayment</i>	60% after <i>deductible</i>
Chiropractic Limits	26 visit(s) per <i>covered person</i> , with no more than 1 visit per day The visit limit applies to the following chiropractic benefits: physical therapy; and manipulations.	
If <i>copayments</i> apply to multiple chiropractic <i>services</i> , one <i>copayment</i> will apply per day per servicing <i>provider</i> .		
Physical therapy when provided by a chiropractor will deplete the chiropractic limits.		
Physical Therapy (Clinic and <i>Outpatient</i>)	80% after <i>deductible</i>	60% after <i>deductible</i>
Physical Therapy Limits	Up to 30 visit(s) per <i>calendar year</i> . May require an authorization.	
Occupational Therapy (Clinic and <i>Outpatient</i>)	80% after <i>deductible</i>	60% after <i>deductible</i>
Occupational Therapy Limits	Up to 30 visit(s) per <i>calendar year</i> . May require an authorization.	
Speech Therapy (Clinic and <i>Outpatient</i>)	80% after <i>deductible</i>	60% after <i>deductible</i>
Speech Therapy Limits	Up to 30 visit(s) per <i>calendar year</i> . May require an authorization.	

SCHEDULE OF BENEFITS (continued)

THERAPY SERVICES		
MEDICAL SERVICES	PAR PROVIDER BENEFIT (IN-NETWORK)	NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)
Cognitive Therapy (Clinic and <i>Outpatient</i>)	80% after <i>deductible</i>	60% after <i>deductible</i>
Cognitive Therapy Limits	30 visit(s) per <i>covered person</i>	
Therapy Education (Clinic and <i>Outpatient</i>)	100% after the applicable <i>qualified practitioner</i> office visit <i>copayment</i>	60% after <i>deductible</i>
If <i>copayments</i> apply to multiple <i>therapy services</i> , one <i>copayment</i> will apply per day per servicing <i>provider</i> .		
Physical, occupational, speech and cognitive therapies and chiropractic services have separate limits.		
Acupuncture	Not Covered	Not Covered
Respiratory Therapy and Pulmonary Therapy (Clinic and <i>Outpatient</i>)	80% after <i>deductible</i>	60% after <i>deductible</i>
Vision Therapy (eye exercises to strengthen the muscles of the eye) (Clinic and <i>Outpatient</i>)	Not Covered	Not Covered
Chemotherapy Clinic	100% after the applicable <i>qualified practitioner</i> office visit <i>copayment</i>	60% after <i>deductible</i>
Inpatient/Outpatient	80% after <i>deductible</i>	60% after <i>deductible</i>

SCHEDULE OF BENEFITS (continued)

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

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

SCHEDULE OF BENEFITS (continued)

TRANSPLANT SERVICES		
<i>Precertification is required, if precertification is not received, organ transplant services will not be covered.</i>		
MEDICAL SERVICES	HUMANA NATIONAL TRANSPLANT NETWORK (NTN) FACILITY (Payable at the <i>PAR</i> Provider Benefit Level) (IN-NETWORK)	NON-HUMANA NATIONAL TRANSPLANT NETWORK (NTN) FACILITY (Payable at the <i>Non-PAR</i> Provider Benefit Level)* (OUT-OF-NETWORK)
Organ Transplant Medical Services	Payable the same as any other <i>sickness</i> .	Payable the same as any other <i>sickness</i> .
Non-Medical Services - Lodging (Limitations apply. See pages 69-71)	80% after <i>deductible</i>	60% after <i>deductible</i>
Non-Medical Services - Transportation (Limitations apply. See pages 69-71)	80% after <i>deductible</i>	60% after <i>deductible</i>
Organ Transplant Medical Services Limits	Lifetime maximum of the <i>Plan</i> .	
Non-Medical Services - Lodging Limits	\$10,000 per covered transplant	
Non-Medical Services - Transportation Limits	\$10,000 per covered transplant	
Lodging and transportation limits are combined.		
<i>Covered expenses for organ transplants performed at a Humana National Transplant Network facility and at a facility other than a Humana National Transplant Network facility will aggregate toward the Plan out-of-pocket limits.</i>		

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

SCHEDULE OF BENEFITS (continued)

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

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

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

SCHEDULE OF BENEFITS (continued)

BEHAVIORAL HEALTH CLINIC, OUTPATIENT AND INTENSIVE OUTPATIENT SERVICES

MEDICAL SERVICES	PAR PROVIDER BENEFIT (IN-NETWORK)	NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)
Diagnostic Examination (Clinic)	Payable the same as any other <i>sickness</i> .	Payable the same as any other <i>sickness</i> .
Laboratory and X-ray (Clinic and <i>Outpatient</i>)	Payable the same as any other <i>sickness</i> .	Payable the same as any other <i>sickness</i> .

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

AUTISM SERVICES

MEDICAL SERVICES	PAR PROVIDER BENEFIT (IN-NETWORK)	NON-PAR PROVIDER BENEFIT* (OUT-OF-NETWORK)
Rehabilitative and Therapeutic Care	80% after <i>deductible</i>	60% after <i>deductible</i>
<i>Respite Care</i> for covered person age 1-21	80% after <i>deductible</i> , and does not apply to the out-of-pocket maximum	Payable the same as <i>PAR Provider</i> Benefit, and does not apply to the out-of-pocket maximum
Autism Respite Services Limit	\$375 monthly benefit (s) per covered person	

SCHEDULE OF BENEFITS (continued)

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

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

MEDICAL COVERED EXPENSES

HOW BENEFITS PAY

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

DEDUCTIBLE

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

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

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

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

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

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

COINSURANCE

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

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

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

OUT-OF-POCKET LIMIT

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

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

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

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

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

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

LIFETIME MAXIMUM BENEFIT

This *Plan* does not include a lifetime maximum.

ROUTINE/PREVENTIVE SERVICES

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

1. Services with an A or B rating in the current recommendations of the U. S. Preventive Services Task Force (USPSTF). The recommendations by the USPSTF for breast cancer screenings, mammography and preventions issued prior to November 2009 will be considered current.
2. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC).
3. Preventive care for infants, children and adolescents provided in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).
4. Preventive care for women provided in the comprehensive guidelines supported by HRSA.

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

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

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

HEARING AIDS AND RELATED SERVICES

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

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

QUALIFIED PRACTITIONER SERVICES

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

MEDICAL COVERED EXPENSES (continued)

Second Surgical Opinion

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

Multiple Surgical Procedures

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

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

No benefits will be payable for incidental procedures.

Surgical Assistant/Assistant Surgeon

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

Physician Assistant

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

DENTAL/ORAL SURGERIES COVERED UNDER THE MEDICAL PLAN

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

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

FAMILY PLANNING

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

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

MATERNITY

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

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

Newborns

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

Birthing Centers

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

INPATIENT HOSPITAL

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

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

MEDICAL COVERED EXPENSES (continued)

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

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

SKILLED NURSING FACILITY

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

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

1. Begins while *you* or an eligible *dependent* are covered under this *Plan*;
2. Begins after discharge from a *hospital confinement* or a prior covered skilled nursing facility *confinement*;
3. Is necessary for care or treatment of the same *bodily injury* or *sickness* which caused the prior *confinement*; and
4. Occurs while *you* or an eligible *dependent* are under the regular care of a physician.

MEDICAL COVERED EXPENSES (continued)

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

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

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

OUTPATIENT AND AMBULATORY SURGICAL CENTER

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

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

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

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

MEDICAL COVERED EXPENSES (continued)

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

EMERGENCY AND URGENT CARE SERVICES

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

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

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

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

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

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

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

HOSPICE SERVICES

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

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

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

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

Hospice care benefits do NOT include:

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

MEDICAL COVERED EXPENSES (continued)

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

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

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

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

HOME HEALTH CARE

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

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

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

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

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

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

MEDICAL COVERED EXPENSES (continued)

The home health care plan consists of:

1. Care by or under the supervision of a registered nurse (R.N.);
2. Physical, speech, occupational, cognitive and respiratory therapy and home health aide *services*; and
3. Medical supplies, laboratory *services* and nutritional counseling, if such *services* and supplies would have been covered if *you* were *hospital confined*.

Home health care benefits do not include:

1. Charges for mileage or travel time to and from the *covered person's* home;
2. Wage or shift differentials for home health care *providers*;
3. Charges for supervision of home health care *providers*;
4. Private duty nursing;
5. *Durable medical equipment* and prosthetics.

DURABLE MEDICAL EQUIPMENT (DME)

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

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

1. The manufacturer's warranty is expired; and
2. Repair or maintenance is not a result of misuse or abuse; and
3. Maintenance is not more frequent than every 6 months; and
4. The repair cost is less than the replacement cost.

Replacement of purchased *DME* is a *covered expense* if:

1. The manufacturer's warranty is expired; and
2. The replacement cost is less than the repair cost; and
3. The replacement is not due to lost or stolen equipment or misuse or abuse of the equipment; or
4. Replacement is required due to a change in condition that makes the current equipment non-functional.

MEDICAL COVERED EXPENSES (continued)

Duplicate *DME* is not covered.

Prosthetics

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

SPECIALTY DRUG MEDICAL BENEFIT

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

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

AMBULANCE

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

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

1. From a *covered person's* home or scene of *accident* or medical *emergency* to the closest facility that can provide *covered services* appropriate to the *covered person's* condition. If there is no facility in the local area that can provide *covered services* appropriate to the *covered person's* condition, *ambulance service* means transportation to the closest facility outside the local area that can provide the necessary *services*;
2. Between *hospitals*; and
3. Between a *hospital* and *nursing facility*, with prior approval of the *Plan*.

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

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

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

MEDICAL COVERED EXPENSES (continued)

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

MORBID OBESITY

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

OBESITY

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

TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ)

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

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

1. Diagnostic examination;
2. Diagnostic x-rays;
3. Injection of muscle relaxants;
4. Therapeutic drug injections;
5. Physical therapy;
6. Diathermy therapy;
7. Ultrasound therapy;
8. Splint therapy; and
9. Arthrocentesis and aspiration.

MEDICAL COVERED EXPENSES (continued)

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

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

DENTAL INJURY

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

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

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

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

THERAPY SERVICES

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

Chiropractic Care

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

TRANSPLANT SERVICES

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

Covered Organ Transplant

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

MEDICAL COVERED EXPENSES (continued)

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

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

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

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

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

MEDICAL COVERED EXPENSES (continued)

Exclusions

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

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

Covered Services

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

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

MEDICAL COVERED EXPENSES (continued)

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

BEHAVIORAL HEALTH SERVICES

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

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

Inpatient Services

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

Outpatient Services

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

Autism Services

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

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

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

MEDICAL COVERED EXPENSES (continued)

Kentucky Employee Assistance Program (KEAP)

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

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

Limitations

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

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

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

OTHER COVERED EXPENSES

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

1. Blood and blood plasma are payable as long as it is NOT replaced by donation, and administration of blood and blood products including blood extracts or derivatives;
2. Casts, trusses, crutches, *orthotics*, splints and braces. Oral or dental splints and appliances must be custom made and for the treatment of documented obstructive sleep apnea. Unless specifically stated otherwise, fabric supports, replacement *orthotics* and braces, oral splints and appliances, dental splints and appliances, and dental braces are not a *covered expense*;
3. Reconstructive *surgery* due to *bodily injury*, infection or other disease of the involved part or congenital disease or anomaly of a covered *dependent* child which resulted in a *functional impairment*;
4. Reconstructive *services* following a covered mastectomy, including but not limited to:
 - a. Reconstruction of the breast on which the mastectomy was performed;
 - b. Reconstruction of the other breast to achieve symmetry;
 - c. Prosthesis; and
 - d. Treatment of physical complications of all stages of the mastectomy, including lymphedemas;

MEDICAL COVERED EXPENSES (continued)

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

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

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

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

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

9. Cochlear implants;

10. Therapy and testing for treatment of allergies, including but not limited to, skin titration (Rinkel Test), cytotoxicity testing (Bryan's Test), urine auto injection, provocative and neutralization testing for allergies, or for an assessment of IgG antibodies in food allergies, *services* related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts, neutralization test and/or treatment UNLESS such therapy or testing is NOT approved by:
 - a. The American Academy of Allergy and Immunology, or
 - b. The Department of Health and Human Services or any of its offices or agencies;

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

LIMITATIONS AND EXCLUSIONS

This *Plan* does not provide benefits for:

1. *Services*:
 - a. Not furnished by a *qualified practitioner* or *qualified treatment facility*;
 - b. Not authorized or prescribed by a *qualified practitioner*;
 - c. Not specifically covered by this *Plan* whether or not prescribed by a *qualified practitioner*;
 - d. Which are not provided;
 - e. For which no charge is made, or for which *you* would not be required to pay if *you* were not covered under this *Plan* unless charges are received from and reimbursable to the United States Government or any of its agencies as required by law;
 - f. Furnished by or payable under any plan or law through any government or any political subdivision (this does not include *Medicare* or *Medicaid*);
 - g. Furnished for a military service connected *sickness* or *bodily injury* by or under an agreement with a department or agency of the United States Government, including the Department of Veterans Affairs;
 - h. Performed in association with a *service* that is not covered under this *Plan*;
 - i. Performed as a result of a complication arising from a *service* that is not covered under this *Plan*.
2. Immunizations required for foreign travel;
3. Radial keratotomy, refractive keratoplasty or any other *surgery* to correct myopia, hyperopia or stigmatic error;
4. *Services* related to gender change;
5. *Cosmetic surgery* and *cosmetic services*, devices or supplies and complications arising directly from the *cosmetic services*, unless for reconstructive *surgery*:
 - a. Resulting from a *bodily injury*, infection or other disease of the involved part, when *functional impairment* is present; or
 - b. Resulting from a congenital disease or anomaly of a covered *dependent* child which resulted in a *functional impairment*.

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

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

6. Hair prosthesis, hair transplants or hair implants;

LIMITATIONS AND EXCLUSIONS (continued)

7. Dental *services* except as otherwise specifically provided, *services*, supplies, or other care for dental *services* and procedures involving tooth structures, extractions, gingival tissues, alveolar processes, dental x-rays (other than for an accidental injury), procedures of dental origin, odontogenic cysts/tumors, or any orthodontic, or periodontic treatment regardless of *medical necessity*, except that *hospital services* may be covered provided such *services* are pre-certified as *medically necessary* to safeguard the health of the *covered person* from the effects or side effects of a dental procedure due to a specific non-dental organic impairment. *Services* and supplies for maxillary and/or mandibular augmentation/implant procedures to facilitate the use of full or partial dental prosthesis, fixed or removable;
8. *Services* which are:
 - a. Rendered in connection with a *mental health* disorder not classified in the International Classification of Diseases of the U.S. Department of Health and Human Services;
 - b. Extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation.
9. *Services*, supplies, or other care provided for conditions related to conduct disorders (except attention deficit disorders), pervasive developmental disorders (except *autism*), behavioral disorders, learning disabilities and disorders, or mental retardation. *Services*, supplies or other care for non-chemical addictions such as gambling, sexual, spending, shopping and working addictions, codependency, or caffeine addition. Milieu therapy, marriage counseling, *inpatient admissions* for environmental change, biofeedback, neuromuscular re-education, hypnotherapy, sleep therapy, vocational rehabilitation, sensory integration, educational therapy and recreational therapy, except for such adjunct *services* as part of the *inpatient* stay and required by the Joint Commission on Accreditation of Healthcare Organizations or the Commission of Accreditation of Rehabilitative Facilities;
10. *Court-ordered mental health or substance abuse services*;
11. Education or training, unless otherwise specified in this *Plan*;
12. Educational or vocational therapy, testing, services or schools, including therapeutic boarding schools and other therapeutic environments. Educational or vocational videos, tapes, books and similar materials are also excluded;
13. Expenses for *services* that are primarily and customarily used for environmental control or enhancement (whether or not prescribed by a *qualified practitioner*) and certain medical devices including, but not limited to:
 - a. Common household items including air conditioners, humidifiers, dehumidifiers, air purifiers, water purifiers, vacuum cleaners, waterbeds, hypoallergenic mattresses or pillows or exercise and massage equipment;
 - b. Motorized transportation equipment (e.g. scooters), escalators, elevators, seat lift chairs, ramps or modifications or additions to living/working quarters or transportation vehicles;
 - c. Personal hygiene equipment including bath/shower chairs, transfer equipment or supplies or bed side commodes;
 - d. Personal comfort items including cervical pillows, gravity lumbar reduction chairs, swimming pools, whirlpools, spas or saunas;
 - e. Medical equipment including blood pressure monitoring devices, PUVA lights and stethoscopes;

LIMITATIONS AND EXCLUSIONS (continued)

- f. Communication system, telephone, television or computer systems and related equipment or similar items or equipment;
 - g. Communication devices, except after surgical removal of the larynx or a diagnosis of permanent lack of function of the larynx;
 - h. *Durable medical equipment*, prosthesis, or orthotic device having convenience or luxury features which are not *medically necessary*, except that benefits for the cost of standard equipment or device used in the treatment of disease, *sickness*, or injury will be provided toward the cost of any deluxe equipment, prosthetic or device selected;
 - i. Vehicle adjustments, stair-gliders, *emergency* alert equipment, handrails, heat appliances.
14. Charges for:
- a. Failure to keep a scheduled visit;
 - b. Completion of a *claim* form; or
 - c. Providing requested information to the *Plan*.
15. Any medical treatment, procedure, drug, biological product or device which is *experimental, investigational or for research purposes*, unless otherwise specified in this *Plan*;
16. *Services* that are not *medically necessary*, except routine/preventive *services*;
17. Charges in excess of the *maximum allowable fee* for the *service*;
18. *Services* provided by a person who ordinarily resides in *your* home or who is a *family member*;
19. Any *expense incurred* prior to *your effective date* under this *Plan* or after the date *your* coverage under this *Plan* terminates, except as specifically described in this *Plan*;
20. *Expenses incurred* for which *you* are entitled to receive benefits under *your* previous dental or medical plan;
21. Any expense due to the *covered person's*:
- a. Engaging in an illegal occupation; or
 - b. Commission of or an attempt to commit a criminal act.
22. *Services*, supplies, or other care provided in treatment of injuries sustained or illnesses resulting from participation in a riot or civil disturbance or while committing or attempting to commit an assault or felony. *Services*, supplies or other care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs;
23. Any loss caused by or contributed to:
- a. War or any act of war, whether declared or not;
 - b. Insurrection; or
 - c. Any act of armed conflict, or any conflict involving armed forces of any authority.
24. Any *expense incurred* for *services* received outside of the United States, except for *emergency care services*, unless otherwise determined by this *Plan*;

LIMITATIONS AND EXCLUSIONS (continued)

25. Treatment of nicotine habit or addiction, including, but not limited to hypnosis, smoking cessation products (except as covered and provided through the Pharmacy Benefit Manager), classes or tapes, unless otherwise determined by this Plan;
26. Food, dietary supplements and dietary formulas (except special formulas *medically necessary* for the treatment of certain inborn errors of metabolism including phenylketonuria (PKU)), minerals, vitamins, or drugs which could be purchased without a written prescription, or are not FDA approved for treatment of a specified category of medical conditions, or are not *medically necessary*, or are considered to be *experimental* or *investigational*, except as provided through the Pharmacy Benefit Manager's Summary Plan Description;
27. *Prescription* drugs and *self-administered injectable drugs*, unless administered to you:
 - a. While *inpatient* in a *hospital*, *qualified treatment facility* or skilled nursing facility;
 - b. By the following, when deemed appropriate by this *Plan*: a *qualified practitioner*, during an office visit, while *outpatient*, or at a home health care agency as part of a covered home health care plan approved by this *Plan*; or
 - c. Provided through the Pharmacy Benefit Manager's Summary Plan Description.
28. Any drug prescribed, except:
 - a. FDA approved drugs utilized for FDA approved indications; or
 - b. FDA approved drugs utilized for *off-label drug indications* recognized in at least one compendia reference or peer-reviewed medical literature deemed acceptable to this *Plan*.
29. *Off-evidence drug indications*;
30. Over-the-counter medical items or supplies that can be provided or prescribed by a *qualified practitioner* but are also available without a written order or *prescription*, except for preventive *services* (with a *prescription* from a *qualified practitioner*);
31. Growth hormones (medications, drugs or hormones to stimulate growth);
32. Therapy and testing for treatment of allergies including, but not limited to, *services* related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts, neutralization test and/or treatment UNLESS such therapy or testing is approved by:
 - a. The American Academy of Allergy and Immunology, or
 - b. The Department of Health and Human Services or any of its offices or agencies.
33. Professional pathology or radiology charges, including but not limited to, blood counts, multi-channel testing, and other clinical chemistry tests, when:
 - a. The *services* do not require a professional interpretation, or
 - b. The *qualified practitioner* did not provide a specific professional interpretation of the test results of the *covered person*.
34. *Services* that are billed incorrectly or billed separately, but are an integral part of another billed *service*;

LIMITATIONS AND EXCLUSIONS (continued)

35. Expenses for health clubs or health spas, aerobic and strength conditioning, work-hardening programs or weight loss or similar programs, and all related material and product for these programs;
36. *Alternative medicine*;
37. *Services* rendered in a premenstrual syndrome clinic or holistic medicine clinic;
38. *Services* of a midwife, unless provided by a Certified Nurse Midwife;
39. The following types of care of the feet, unless medically necessary:
 - a. Shock wave therapy of the feet.
 - b. The treatment of weak, strained, flat, unstable or unbalanced feet.
 - c. Hygienic care, and the treatment of superficial lesions of the feet, such as corns, calluses or hyperkeratosis.
 - d. The treatment of tarsalgia, metatarsalgia, or bunion, except surgically.
 - e. The cutting of toenails, except the removal of the nail matrix.
 - f. The provision of heel wedges, lifts or shoe inserts, arch supports or orthopedic shoes..
40. *Custodial care* and *maintenance care*, supplies, or other care rendered by or in: (a) rest homes; (b) health resorts; (c) homes for the aged; (d) places primarily for domiciliary or *custodial care*; and (e) self-help training or other forms of non-medical self-care;
41. Weekend non-emergency *hospital admissions*, specifically *admissions* to a *hospital* on a Friday or Saturday at the convenience of the *covered person* or his or her *qualified practitioner* when there is no cause for an *emergency admission* and the *covered person* receives no *surgery* or therapeutic treatment until the following Monday;
42. *Hospital inpatient services* when you are in observation status;
43. *Services* rendered by a standby physician, surgical assistant, assistant surgeon, *physician assistant*, registered nurse or certified operating room technician unless *medically necessary*;
44. *Ambulance services* for routine transportation to, from or between medical facilities and/or a *qualified practitioner's* office. Travel or transportation expenses (except *ambulance*), even though prescribed by a *physician*. Air *ambulance* is excluded, unless *emergency medical services*, the attending *physician*, or the *Plan* determines an air *ambulance* is the only medically appropriate means of transportation to the nearest appropriate facility;
45. *Preadmission testing/procedural testing* duplicated during a *hospital confinement*;
46. Lodging accommodations or transportation, unless specifically provided under this *Plan*;
47. Communications or travel time;

LIMITATIONS AND EXCLUSIONS (continued)

48. No benefits will be provided for the following, unless otherwise determined by this *Plan*:
 - a. Immunotherapy for recurrent abortion;
 - b. Chemonucleolysis;
 - c. Biliary lithotripsy;
 - d. Home uterine activity monitoring;
 - e. Sleep therapy;
 - f. Light treatments for Seasonal Affective Disorder (S.A.D.);
 - g. Immunotherapy for food allergy;
 - h. Prolotherapy;
 - i. Cranial banding;
 - j. Hyperhidrosis *surgery*;
 - k. Lactation therapy; or
 - l. Sensory integration therapy.
49. Any *covered expenses* to the extent of any amount received from others for the *bodily injuries* or losses which necessitate such benefits. Without limitation, "amounts received from others" specifically includes, but is not limited to, liability insurance, workers' compensation, uninsured motorists, underinsured motorists, "no-fault" and automobile med-pay payments or recovery from any identifiable fund regardless of whether the *beneficiary* was made whole;
50. *Services*, supplies, or other care to the extent that benefits or reimbursement are available from or provided by any other group coverage, except that the *Plan* will coordinate the payment of benefits under this plan with such other coverage, as permitted by Kentucky Law;
51. Physical exams/immunizations (except as otherwise provided), *services*, supplies, or other care for routine or periodic physical examinations, immunizations, or tests for screening purposes required by third parties, such as for employment, licensing, travel, school (except approved well visits), insurance, marriage, adoption, participation in athletics, or *services* conducted for medical research or examinations required by a court;
52. Surrogate parenting;
53. Work-related health conditions if the *covered person* is eligible for workers' compensation insurance and the condition is determined to be work-related and benefits are payable under workers' compensation insurance;
54. Routine vision examinations;
55. Routine vision refraction;
56. The purchase, fitting or repair of eyeglass frames and lenses or contact lenses, unless specifically provided under this *Plan*;
57. Vision therapy;
58. Routine hearing examinations;
59. Routine hearing testing or screening, other than the screening of a newborn in the *hospital*;

LIMITATIONS AND EXCLUSIONS (continued)

60. *Hearing aids*, the fitting or repair of *hearing aids* or advice on their care; implantable hearing devices, except for cochlear implants and auditory brain stem implants as determined by this *Plan* or unless specifically provided under this *Plan*;
61. Elective medical or surgical abortion, unless:
 - a. The pregnancy would endanger the life of the mother; or
 - b. The pregnancy is a result of rape or incest; or
 - c. The fetus has been diagnosed with a lethal or otherwise significant abnormality.
62. *Services* for a reversal of sterilization;
63. Contraceptive pills and patches, abortifacients and spermicide (see the Prescription Drug Benefit for coverage);
64. Surgical procedures for the removal of excess fat and/or skin in conjunction with or resulting from weight loss due to obesity, *surgery*, or pregnancy or *services* at a health spa or similar facility. *Services*, supplies, or other care for gastric bubble/gastric balloon procedures, stomach stapling, wiring of the jaw, liposuction and jejunal bypasses. Dietary supplements, diet pills and appetite suppressants;
65. Dental osteotomies;
66. Infertility counseling and treatment *services*;
67. Artificial means to achieve pregnancy or ovulation, including, but not limited to, artificial insemination, in vitro fertilization, spermatogenesis, gamete intra fallopian transfer (GIFT), zygote intra fallopian transfer (ZIFT), tubal ovum transfer, embryo freezing or transfer and sperm banking;
68. *Services* related to the treatment and/or diagnosis of sexual dysfunction/impotence;
69. Penile implants and prosthetics, or any other *services* for the diagnosis or treatment of sexual dysfunction/impotence are not covered unless related to penile trauma or amputation, or unless related to reconstructive *services* related to penile trauma or amputation, or after prostate, bladder, bowel or spinal injury;
70. *Services*, supplies and other care for acupuncture, anesthesia by hypnosis, or anesthesia charges for *services* not covered by this plan;
71. No benefits are payable under this provision for residential treatment *services* or any *services* performed at a *Residential treatment facilities*;
72. Halfway-house *services*;
73. Disposable supplies, normally purchased in an over the counter setting, to an *outpatient* facility including, but not limited to, ace bandages, support hosiery, pressure garments, elastic stockings, and band-aid's;
74. Chelation therapy except in the treatment of lead or other heavy metal poisoning;
75. *Services*, supplies, or other care for educational or training procedures used in connection with speech except as otherwise defined in the therapy or hearing *services* section;

LIMITATIONS AND EXCLUSIONS (continued)

76. *Services*, supplies, or other care provided to an *inpatient* solely for cardiac rehabilitation. *Services*, supplies, or other care provided for non-human, artificial, or mechanical hearts or ventricular and/or atrial assist devices used as a heart replacement (when not otherwise provided in conjunction with a human organ transplant) and supportive *services* or devices in connection with such care. This exclusion includes *services* for implantation, removal, and complications;
77. Food, housing, home delivered meals, and homemaker services (such as housekeeping, laundry, shopping and errands). Teaching household routine to members of the *covered person's* family; supervision of a *covered person's* children; and other similar functions. Benefits are not provided for home health care education beyond the normal and customary period for learning. Supportive environmental materials, including hand rails, ramps, telephones, air conditioners and similar items. *Services* or supplies provided by the family of the *covered person* or volunteer *ambulance* associations. Visiting teachers, friendly visitors, vocational guidance, and other counselors. *Services* related to diversional and social activities. *Services* for which there is no cost to the *covered person*;
78. Non-emergency diagnostic *admissions* for inpatients or *admissions* primarily for therapy *services*, unless pre-authorized by the *Plan*;
79. *Services*, supplies, and other care related to suction-assisted lipectomy or diastasis recti repair, including instances when diastasis recti is associated with an umbilical or ventral hernia;
80. *Services*, supplies, or other care to the extent that *Medicare* is the primary payer. The *Plan* will coordinate the payment of benefits under this *plan* with *Medicare*, as permitted by Kentucky and Federal law;
81. *Services* or supplies for *mental health conditions* unless performed by a *physician* or other *provider* who is licensed or certified by the Commonwealth of Kentucky (or a corresponding licensing or certifying authority when the service is provided outside of the Commonwealth). *Services* for *mental health conditions* when provided for purposes of medical, educational, or occupational training. Psychological testing beyond that necessary to establish a diagnosis or beyond that approved by the subcontractor;
82. *Services*, supplies, or other care not meeting a *Plan's plan delivery system rules*;
83. Drugs that can be purchased without a written prescription. Amino acid modified preparations and low-protein modified food products for the treatment of lactose intolerance, protein intolerance, food allergy, food insensitivity, except as provided through the Pharmacy Benefit Manager's Summary Plan Description;
84. Marriage counseling.

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

COORDINATION OF BENEFITS

BENEFITS SUBJECT TO THIS PROVISION

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

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

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

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

EFFECT ON BENEFITS

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

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

ORDER OF BENEFIT DETERMINATION

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

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

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

COORDINATION OF BENEFITS (continued)

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

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

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

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

COORDINATION OF BENEFITS WITH MEDICARE

TRICARE AS SECONDARY PAYER

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

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

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

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

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

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

COORDINATION OF BENEFITS (continued)

OPTIONS

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

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

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

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

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

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

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

CALCULATION AND PAYMENT OF BENEFITS

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

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

RIGHT OF RECOVERY

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

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

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

HEALTH CARE CLAIM PROCEDURES

SUBMITTING A CLAIM

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

- A *claim* must be filed with Humana in writing and delivered to Humana by mail, postage prepaid. However, a submission to obtain pre-authorization may also be filed with Humana by telephone;
- *Claims* must be submitted to Humana at the address indicated in the documents describing this *Plan* or *claimant's* identification card. *Claims* will not be deemed submitted for purposes of these procedures unless and until received at the correct address;
- Also, *claims* submissions must be in a format acceptable to Humana and compliant with any applicable legal requirements. *Claims* that are not submitted in accordance with the requirements of applicable federal law respecting privacy of *protected health information* and/or electronic *claims* standards will not be accepted by this *Plan*;
- *Claims* submissions must be timely. *Claims* must be filed as soon as reasonably possible after they are incurred, and in no event later than 15 months after the date of loss, except if *you* were legally incapacitated. *Plan* benefits are only available for *claims* that are incurred by a *covered person* during the period that he or she is covered under this *Plan*;
- *Claims* submissions must be complete. They must contain, at a minimum:
 - a. The name of the *covered person* who incurred the *covered expense*;
 - b. The name and address of the health care *provider*;
 - c. The diagnosis of the condition;
 - d. The procedure or nature of the treatment;
 - e. The date of and place where the procedure or treatment has been or will be provided;
 - f. The amount billed and the amount of the *covered expense* not paid through coverage other than *Plan* coverage, as appropriate;
 - g. Evidence that substantiates the nature, amount, and timeliness of each *covered expense* in a format that is acceptable according to industry standards and in compliance with applicable law.

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

Mail medical *claims* and correspondence to:

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

MISCELLANEOUS MEDICAL CHARGES

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

PROCEDURAL DEFECTS

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

ASSIGNMENTS AND REPRESENTATIVES

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

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

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

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

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

CLAIMS DECISIONS

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

Pre-Service Claims

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

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

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

Urgent Care Claims

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

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

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

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

Concurrent Care Decisions

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

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

Post-Service Claims

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

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

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

TIMES FOR DECISIONS

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

PAYMENT OF CLAIMS

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

HEALTH CARE CLAIM PROCEDURES (continued)

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

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

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

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

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

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

NOTICES – GENERAL INFORMATION

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

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

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

INITIAL DENIAL NOTICES

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

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

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

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

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

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

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

APPEALS / GRIEVANCES

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

APPEALS OF ADVERSE BENEFIT DETERMINATIONS

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

HEALTH CARE CLAIM PROCEDURES (continued)

A first level and second level *appeal* must be made by a *claimant* by means of written application, in person, or by mail (postage prepaid), addressed to:

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

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

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

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

Time Periods for Decisions on Appeal -- First Level

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

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

HEALTH CARE CLAIM PROCEDURES (continued)

Time Periods for Decisions on Appeal -- Second Level

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

<i>Pre-Service Claims</i>	Within a reasonable period, but not later than 15 days after Humana receives the <i>appeal</i> request.
<i>Post-Service Claims</i>	Within a reasonable period, but no later than 30 days after Humana receives the <i>appeal</i> request.

APPEAL DENIAL NOTICES

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

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

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

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

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

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

FULL AND FAIR REVIEW

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

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

RIGHT TO REQUIRE MEDICAL EXAMINATIONS

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

EXHAUSTION

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

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

LEGAL ACTIONS AND LIMITATIONS

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

Request for an External Review

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

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

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

Preliminary Review

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

1. If the *claimant* is, or was, covered under this Plan at the time the health care item or *service* was requested or provided;
2. If the *adverse benefit determination* or *final internal adverse benefit determination* relates to the *claimant's* failure to meet this Plan's eligibility requirements;
3. If the *claimant* has exhausted this Plan's *internal appeals* process, when required; and
4. If the *claimant* has provided all the information and forms required to process an *external review*.

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

1. If the request is complete but not eligible for *external review*. The notice must include the reason(s) for its ineligibility and contact information for the Department of Health and Human Services Health Insurance Assistance Team (HIAT), including this number: 1-888-393-2789.
2. If the request is not complete. The notice must describe the information or materials needed to make it complete, and Humana must allow the *claimant* to perfect the *external review* request within whichever of the following two options is later:
 - a. The initial 4-month filing period; or
 - b. The 48-hour period following receipt of the notification.

Referral to an Independent Review Organization (IRO)

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

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

1. The assigned *IRO* will use legal experts where appropriate to make coverage determinations.
2. The assigned *IRO* will timely provide the *claimant* with written notification of the request's eligibility and acceptance of the request for *external review*. This written notice must inform the *claimant* that he/she may submit, in writing, additional information that the *IRO* must consider when conducting the *external review* to the *IRO* within 10 business days following the date the notice is received by the *claimant*. The *IRO* may accept and consider additional information submitted after 10 business days.
3. Humana must provide the *IRO* the documents and any information considered in making the *adverse benefit determination* or *final internal adverse benefit determination* within 5 business days after assigning the *IRO*. Failure to timely provide this information must not delay the conduct of the *external review* - the assigned *IRO* may terminate the *external review* and make a decision to reverse the *adverse benefit determination* or *final internal adverse benefit determination* if this Plan fails to timely provide this information. The *IRO* must notify the *claimant* and Humana within 1 business day of making the decision.
4. If the *IRO* receives any information from the *claimant*, the *IRO* must forward it to Humana within 1 business day. After receiving this information, Humana may reconsider its *adverse benefit determination* or *final internal adverse benefit determination*. If Humana reverses or changes its original determination, Humana must notify the *claimant* and the *IRO*, in writing, within 1 business day. The assigned *IRO* will then terminate the *external review*.
5. The *IRO* will review all information and documents timely received. In reaching a decision, the *IRO* will not be bound by any decisions or conclusions reached during Humana's internal claims and *appeals* process. The *IRO*, to the extent the information or documents are available and the *IRO* considers them appropriate, will consider the following when reaching a determination:
 - a. The *claimant's* medical records;
 - b. The attending health care professional's recommendation;
 - c. Reports from the appropriate health care professional(s) and other documents submitted by Humana, *claimant*, or *claimant's* treating provider;
 - d. The terms of the *claimant's* plan to ensure the *IRO's* decision is not contrary, unless the terms are inconsistent with applicable law;
 - e. Appropriate practice guidelines, including applicable evidence-based standards that may include practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;
 - f. Any applicable clinical review criteria developed and used by this Plan, unless inconsistent with the terms of this Plan or with applicable law; and

HEALTH CARE CLAIM PROCEDURES (continued)

- g. The opinion of the *IRO's* clinical reviewer(s) after considering the information described above to the extent the information or documents are available and the reviewer(s) consider them appropriate.
- 6. The assigned *IRO* must provide written notice of the *final external review decision* within 45 days after receiving the *external review* request to the *claimant* and Humana. The decision notice must contain the following:
 - a. A general description of the reason an *external review* was requested, including information sufficient to identify the claim including:
 - (1) The date(s) of service;
 - (2) The health care provider;
 - (3) The claim amount (if applicable); and
 - (4) The reason for the previous denial.
 - b. The date the *IRO* received assignment to conduct the *external review* and the date of the *IRO* decision;
 - c. References to the evidence or documentation considered in reaching the decision, including the specific coverage provisions and evidence-based standards;
 - d. A discussion of the principal reason(s) for its decision, including the rationale and any evidence-based standards relied on in making the decision;
 - e. A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either Humana or the *claimant*;
 - f. A statement that judicial review may be available to the *claimant*; and
 - g. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PPACA (*section 2793 of PHSA, as amended*).
- 7. After a *final external review decision*, the *IRO* must maintain records of all claims and notices associated with the *external review* process for 6 years. An *IRO* must make such records available for examination by the *claimant*, Humana, or state/federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

Reversal of this Plan's Decision

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

EXPEDITED EXTERNAL REVIEW**Request for an Expedited External Review**

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

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

- 1. An *adverse benefit determination* involving a medical condition of the *claimant* for which the time frame for completion of an expedited *internal appeal* under the interim final regulations would seriously jeopardize the life or health of the *claimant*, or would jeopardize the *claimant's* ability to regain maximum function and the *claimant* has filed a request for an expedited *external review*; or

HEALTH CARE CLAIM PROCEDURES (continued)

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

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

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

Preliminary Review

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

Referral to an Independent Review Organization (IRO)

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

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

Notice of Final External Review Decision

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

IF YOU HAVE QUESTIONS

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

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

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

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

SECTION 3

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

OPEN ENROLLMENT

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

EMPLOYEE ELIGIBILITY

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

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

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

EMPLOYEE EFFECTIVE DATE OF COVERAGE

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

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

DEPENDENT ELIGIBILITY

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

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

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

Each *dependent* is eligible for coverage on:

1. The date the *employee* is eligible for coverage, if he or she has *dependents* who may be covered on that date; or
2. The date of birth of the *employee's* natural-born child; or

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE (continued)

3. The date a child is placed for adoption under the *employee's* legal guardianship, or the date which the *employee* incurs a legal obligation for total or partial support in anticipation of adoption; or
4. The date a covered *employee's* child is determined to be eligible as an alternate recipient under the terms of a medical child support order.

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

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

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

DEPENDENT EFFECTIVE DATE OF COVERAGE

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

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

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

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

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

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

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

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE (continued)

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

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

1. If the completed enrollment forms are signed by *you* within 35 days after the *qualifying event* that *dependent* is covered on the coverage *effective date* as set forth in the *qualifying events* in Exhibit A at the end of this document.
2. If the completed enrollment forms are signed by *you* more than 35 days after the *dependent's* eligibility date, the *dependent* is a *late applicant*. The *dependent* will not be eligible for coverage under this *Plan* until the next annual Open Enrollment Period. The *dependent* is covered as determined by the *employer*.

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

FAMILY CROSS-REFERENCE PAYMENT OPTION

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

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

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

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

TERMINATING THE FAMILY CROSS-REFERENCE PAYMENT OPTION

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

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

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

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

MEDICAL CHILD SUPPORT ORDERS

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

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

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

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

SPECIAL PROVISIONS

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

TERMINATING EMPLOYMENT

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

REINSTATEMENT OF COVERAGE

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

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

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

FAMILY AND MEDICAL LEAVE ACT (FMLA)

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

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE (continued)

EXTENDED BENEFITS

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

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

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

RETIREE COVERAGE

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

SURVIVORSHIP COVERAGE

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

SPECIAL ENROLLMENT

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

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

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE (continued)

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

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

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

1. Marriage;
2. Birth;
3. Adoption or placement for adoption;
4. Loss of eligibility due to termination of Medicaid or State Children's Health Insurance Program (SCHIP) coverage; or
5. Eligibility for *premium* assistance subsidy under Medicaid or SCHIP.

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

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

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

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

Please see *your employer* for more details.

COVERAGE TERMINATION DUE TO PLAN CHANGE

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

1. If a covered *member* is hospitalized when coverage would normally terminate, the prior Insurance Carrier that covered the *member's* hospitalization during the previous plan year would continue coverage until the *member* is released from the *hospital* or transferred to another facility. At the time the *member* is released from the *hospital* or transferred to a new facility, the succeeding Insurance Carrier will assume responsibility for that *member*. It is the *member's* responsibility to ensure that a transfer or re-hospitalization is to a participating facility in compliance with all *Plan* delivery rules.
2. If a *member* has *family coverage* and a covered *dependent* is hospitalized when coverage would normally terminate due to a change in Insurance Carriers, the hospitalized family member would continue his/her prior coverage until discharge from the *hospital* or transfer to another facility. All other covered *dependents* not hospitalized at the date the new coverage begins would be transferred to the new *Plan* on the date the new coverage starts (not on the date the hospitalized *dependent* is released or transferred).
3. If a covered *member* is not at work and/or is on unofficial leave without pay or otherwise continuing to pay for his/her own health insurance *premiums* on the group coverage, that participant will begin coverage with his/her succeeding Insurance Carrier on January 1, even though he/she is not at work.

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

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

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

TERMINATION OF COVERAGE

Coverage terminates on the earliest of the following:

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

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

SECTION 4
GENERAL PROVISIONS
**AND REIMBURSEMENT/
SUBROGATION**

GENERAL PROVISIONS

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

PLAN ADMINISTRATION

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

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

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

RESCISSION

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

CONTESTABILITY

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

RIGHT TO REQUEST OVERPAYMENTS

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

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

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

TIME LIMIT ON CERTAIN DEFENSES

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

WORKERS' COMPENSATION NOT AFFECTED

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

WORKERS' COMPENSATION

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

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

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

MEDICAID

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

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

CONSTRUCTION OF PLAN TERMS

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

REIMBURSEMENT/SUBROGATION

RIGHT OF RECOVERY

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

SUBROGATION

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

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

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

REIMBURSEMENT/SUBROGATION (continued)

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

PLAN’S RIGHT TO ASSERT CLAIMS ON YOUR BEHALF

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

MISCELLANEOUS SUBROGATION

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

DUTY TO COOPERATE

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

RETENTION OF AN ATTORNEY

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

PARTICIPANT'S NONCOMPLIANCE

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

RIGHT TO COLLECT NEEDED INFORMATION

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

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

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

REIMBURSEMENT/SUBROGATION EXCLUSIONS

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

SECTION 5

NOTICES

IMPORTANT NOTICES FOR EMPLOYEES AND SPOUSES AGE 65 AND OVER

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

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

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

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

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

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

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

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

IMPORTANT NOTICES FOR EMPLOYEES AND SPOUSES AGE 65 AND OVER (continued)

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

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

PRIVACY OF PROTECTED HEALTH INFORMATION

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

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

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

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

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

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

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

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

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

PRIVACY OF PROTECTED HEALTH INFORMATION (continued)

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

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

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

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

CONTINUATION OF MEDICAL BENEFITS

THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1986 (COBRA)

CONTINUATION OF BENEFITS

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

ELIGIBILITY

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

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

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

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

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

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

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

CONTINUATION OF MEDICAL BENEFITS (continued)

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

LOSS OF COVERAGE

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

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

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

NOTICES AND ELECTION

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

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

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

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

CONTINUATION OF MEDICAL BENEFITS (continued)

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

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

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

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

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

MAXIMUM COVERAGE PERIOD

Coverage may continue up to:

- 18 months for an *employee* and/or *dependent* whose group coverage ended due to termination of the *employee's* employment or reduction in hours of employment;
- 36 months for a *spouse* whose coverage ended due to the death of the *employee* or *retiree*, divorce, or the *employee* becoming entitled to *Medicare* at the time of the initial *qualifying event*;
- 36 months for a *dependent* child whose coverage ended due to the divorce of the *employee* parent, the *employee* becoming entitled to *Medicare* at the time of the initial *qualifying event*, the death of the *employee*, or the child ceasing to be a *dependent* under this *Plan*;

CONTINUATION OF MEDICAL BENEFITS (continued)

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

DISABILITY

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

SECOND QUALIFYING EVENT

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

TERMINATION BEFORE THE END OF MAXIMUM COVERAGE PERIOD

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

- The *employer* no longer provides group health coverage to any of its *employees*;
- The *premium* for continuation is not paid timely;

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

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

TYPE OF COVERAGE; PREMIUM PAYMENT

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

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

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

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

OTHER INFORMATION

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

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

PLAN CONTACT INFORMATION

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

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

CONTINUATION OF BENEFITS

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

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

Health Insurance Protection

- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

USERRA affords other rights and protections including reemployment rights and the right to be free from discrimination and retaliation. To view the complete notice of your rights under USERRA, go to http://www.dol.gov/vets/programs/userra/USERRA_Private.pdf.

MEDICAL CONVERSION PRIVILEGE

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

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

1. *Your* coverage ends because *your* employment terminated;
2. *You* are the covered *dependent* former *spouse* or a covered *dependent* child of an *employee* whose marriage ended due to legal annulment, dissolution or divorce;
3. *You* are the surviving *dependent spouse* or child, in the event of the *employee's* death, or at the end of any survivorship continuation provided in the Plan; or
4. *You* have been a covered *dependent* child but no longer meet the definition of *dependent* under the Plan.

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

LIMITATIONS

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

DUPLICATION OF COVERAGE

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

ADDITIONAL NOTICES

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

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

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

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

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

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

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

begins or, if earlier, until coverage would have otherwise terminated under the terms of the *Plan*.

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

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

THE GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (GINA)

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

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

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

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

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

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

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

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

ALABAMA – Medicaid	COLORADO – Medicaid and CHIP
Website: http://www.medicaid.alabama.gov Phone: 1-855-692-5447	Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943
ALASKA – Medicaid	
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	

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

<p style="text-align: center;">ARIZONA – CHIP</p> <p>Website: http://www.azahcccs.gov/applicants</p> <p>Phone (Outside of Maricopa County): 1-877-764-5437</p> <p>Phone (Maricopa County): 602-417-5437</p>	<p style="text-align: center;">FLORIDA – Medicaid</p> <p>Website: https://www.flmedicaidtprecovery.com/</p> <p>Phone: 1-877-357-3268</p> <hr/> <p style="text-align: center;">GEORGIA – Medicaid</p> <p>Website: http://dch.georgia.gov/</p> <p>Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)</p> <p>Phone: 1-800-869-1150</p>
<p style="text-align: center;">IDAHO – Medicaid and CHIP</p> <p>Medicaid Website: www.accesstohealthinsurance.idaho.gov</p> <p>Medicaid Phone: 1-800-926-2588</p> <p>CHIP Website: www.medicaid.idaho.gov</p> <p>CHIP Phone: 1-800-926-2588</p>	<p style="text-align: center;">MONTANA – Medicaid</p> <p>Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml</p> <p>Phone: 1-800-694-3084</p>
<p style="text-align: center;">INDIANA – Medicaid</p> <p>Website: http://www.in.gov/fssa</p> <p>Phone: 1-800-889-9949</p>	<p style="text-align: center;">NEBRASKA – Medicaid</p> <p>Website: www.ACCESSNebraska.ne.gov</p> <p>Phone: 1-800-383-4278</p>
<p style="text-align: center;">IOWA – Medicaid</p> <p>Website: www.dhs.state.ia.us/hipp/</p> <p>Phone: 1-888-346-9562</p>	<p style="text-align: center;">NEVADA – Medicaid</p> <p>Medicaid Website: http://dwss.nv.gov/</p> <p>Medicaid Phone: 1-800-992-0900</p>
<p style="text-align: center;">KANSAS – Medicaid</p> <p>Website: http://www.kdheks.gov/hcf/</p> <p>Phone: 1-800-792-4884</p>	
<p style="text-align: center;">KENTUCKY – Medicaid</p> <p>Website: http://chfs.ky.gov/dms/default.htm</p> <p>Phone: 1-800-635-2570</p>	<p style="text-align: center;">NEW HAMPSHIRE – Medicaid</p> <p>Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf</p> <p>Phone: 603-271-5218</p>

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

<p align="center">LOUISIANA – Medicaid</p> <p>Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447</p>	<p align="center">NEW JERSEY – Medicaid and CHIP</p> <p>Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710</p>
<p align="center">MAINE – Medicaid</p> <p>Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741</p>	
<p align="center">MASSACHUSETTS – Medicaid and CHIP</p> <p>Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120</p>	<p align="center">NEW YORK – Medicaid</p> <p>Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831</p>
<p align="center">MINNESOTA – Medicaid</p> <p>Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629</p>	<p align="center">NORTH CAROLINA – Medicaid</p> <p>Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100</p>
<p align="center">MISSOURI – Medicaid</p> <p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>	<p align="center">NORTH DAKOTA – Medicaid</p> <p>Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604</p>
<p align="center">OKLAHOMA – Medicaid and CHIP</p> <p>Website: http://www.insureoklahoma.org Phone: 1-888-365-3742</p>	<p align="center">UTAH – Medicaid and CHIP</p> <p>Website: http://health.utah.gov/upp Phone: 1-866-435-7414</p>

<p align="center">OREGON – Medicaid and CHIP</p> <p>Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075</p>	<p align="center">VERMONT– Medicaid</p> <p>Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427</p>
<p align="center">PENNSYLVANIA – Medicaid</p> <p>Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462</p>	<p align="center">VIRGINIA – Medicaid and CHIP</p> <p>Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647</p>
<p align="center">RHODE ISLAND – Medicaid</p> <p>Website: www.ohhs.ri.gov Phone: 401-462-5300</p>	<p align="center">WASHINGTON – Medicaid</p> <p>Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext. 15473</p>
<p align="center">SOUTH CAROLINA – Medicaid</p> <p>Website: http://www.scdhhs.gov Phone: 1-888-549-0820</p>	<p align="center">WEST VIRGINIA – Medicaid</p> <p>Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability</p>
<p align="center">SOUTH DAKOTA - Medicaid</p> <p>Website: http://dss.sd.gov Phone: 1-888-828-0059</p>	<p align="center">WISCONSIN Medicaid</p> <p>Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002</p>
<p align="center">TEXAS – Medicaid</p> <p>Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493</p>	<p align="center">WYOMING – Medicaid</p> <p>Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531</p>

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

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

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 10/31/2016)

PLAN DESCRIPTION INFORMATION

1. Proper Name of *Plan*: Kentucky Employees' Health Plan
2. *Plan Sponsor*: Commonwealth of Kentucky
Personnel Cabinet, Department of Employee Insurance
501 High Street
Second Floor
Frankfort, KY 40601
3. *Employer*: Commonwealth of Kentucky
Personnel Cabinet, Department of Employee Insurance
501 High Street
Second Floor
Frankfort, KY 40601

Common Name of *Employer*: Commonwealth of Kentucky
4. *Plan Administrator* and Named Fiduciary:

Commonwealth of Kentucky
Personnel Cabinet, Department of Employee Insurance
501 High Street
Second Floor
Frankfort, KY 40601
5. *Employer* Identification Number: 61-0600439
6. This *Plan* provides medical benefits for participating *employees* and their enrolled *dependents*.
7. *Plan* benefits described in this booklet are effective January 1, 2014.
8. The *Plan year* is January 1 through December 31 of each year.
9. The fiscal year is July 1 through June 30 of each year
10. Service of legal process may be served upon the *Plan Administrator* as shown above or the following agent for service of legal process:

Commonwealth of Kentucky
Executive Director, Office of Legal Services
501 High Street
Third Floor
Frankfort, KY 40601
11. The *Plan Manager* (Humana) is responsible for performing certain delegated administrative duties, including the processing of *claims*. The *Plan Manager* (Humana) and Claim Fiduciary is:

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

PLAN DESCRIPTION INFORMATION (continued)

12. This is a self-insured health benefit *plan*. The cost of this *Plan* is paid with contributions shared by the *employer* and *employee*. Benefits under this *Plan* are provided from the general assets of the *employer* and are used to fund payment of covered *claims* under this *Plan* plus administrative expenses. Please see *your employer* for the method of calculating contributions and the funding mechanism used for the accumulation of assets through which benefits are provided under this *Plan*.
13. Each *employee* of the *employer* who participates in this *Plan* has access to a *Summary Plan Description*, which is this booklet. This booklet will be available through MyHumana.com or <http://kehpk.y.gov>. It contains information regarding eligibility requirements, termination provisions, a description of the benefits provided and other *Plan* information. Changes can occur to the *Summary Plan Description* throughout the year. Such changes will be posted to the KEHP web site listed above.
14. This *Plan's* benefits and/or contributions may be modified or amended from time to time, or may be terminated at any time by the *Plan Sponsor* (Commonwealth of Kentucky). Significant changes to this *Plan*, including termination, will be communicated to participants as required by applicable law.
15. Upon termination of this *Plan*, the rights of the participants to benefits are limited to *claims* incurred and payable by this *Plan* up to the date of termination. *Plan* assets, if any, will be allocated and disposed of for the exclusive benefit of the participating *employees* and their *dependents* covered by this *Plan*, except that any taxes and administration expenses may be made from this *Plan's* assets.
16. This *Plan* does not constitute a contract between the *employer* and any *covered person* and will not be considered as an inducement or condition of the employment of any *employee*. Nothing in this *Plan* will give any *employee* the right to be retained in the service of the *employer*, or for the *employer* to discharge any *employee* at any time.
17. This *Plan* is not in lieu of and does not affect any requirement for coverage by workers' compensation insurance.
18. This *Plan* is included in the Commonwealth of Kentucky Flexible Benefits Plan, a Cafeteria Plan created pursuant to the Internal Revenue Code Subsection 125.

SECTION 6

DEFINITIONS

DEFINITIONS

Italicized terms throughout this *SPD* have the meaning indicated below. Defined terms are italicized wherever found in this *SPD*.

A

Accident means a sudden event that results in a *bodily injury* and is exact as to time and place of occurrence.

Admission means entry into a facility as a registered bed patient according to the rules and regulations of that facility. An *admission* ends when *you* are discharged, or released, from the facility and *you* are no longer registered as a bed patient.

Advanced imaging, for the purpose of this definition, means Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Positron Emission Tomography (PET), Single Photon Emission Computed Tomography (SPECT) and Computed Tomography (CT) imaging.

Adverse determination means a determination by the *Plan Manager* (Humana) that the health care services furnished or proposed to be furnished to *you* are not *medically necessary* or are *experimental or investigational*; therefore, benefit coverage is denied, reduced or terminated.

Alternative medicine means an approach to medical diagnosis, treatment or therapy that has been developed or practiced NOT using the generally accepted scientific methods in the United States of America. For purposes of this definition, *alternative medicine* shall include, but is not limited to: acupressure, aromatherapy, ayurveda, biofeedback, faith healing, guided mental imagery, herbal medicine, holistic medicine, homeopathy, hypnosis, macrobiotics, naturopathy, ozone therapy, reflexotherapy, relaxation response, rolfing, shiatsu and yoga.

Ambulance means a professionally operated vehicle, provided by a licensed *ambulance* service, equipped for the transportation of a sick or injured person to or from the nearest medical facility qualified to treat the person's *sickness* or *bodily injury*. Use of the *ambulance* must be *medically necessary* and/or ordered by a *qualified practitioner*.

Ambulatory surgical center means an institution which meets all of the following requirements:

1. It must be staffed by physicians and a medical staff which includes registered nurses;
2. It must have permanent facilities and equipment for the primary purpose of performing *surgery*;
3. It must provide continuous physicians' *services* on an *outpatient* basis;
4. It must admit and discharge patients from the facility within a 24-hour period;
5. It must be licensed in accordance with the laws of the jurisdiction where it is located. It must be operated as an *ambulatory surgical center* as defined by those laws;
6. It must not be used for the primary purpose of terminating pregnancies, or as an office or clinic for the private practice of any physician or dentist.

Appeal (or ***internal appeal***) means review by this Plan of an *adverse benefit determination*.

DEFINITIONS (continued)

Autism means a condition affecting a *covered person* ages one (1) through twenty-one (21) years of age, which includes:

- (A) A total of six (6) or more items from subparagraphs 1, 2, and 3 of this paragraph, with at least two (2) from subparagraph 1 and one (1) each from subparagraphs 2 and 3:
 - 1. Qualitative impairment in social interaction, as manifested by at least two (2) of the following:
 - a. Marked impairment in the use of multiple nonverbal behavior such as eye-to-eye gaze, facial express, body postures, and gestures to regulate social interaction;
 - b. Failure to develop peer relationships appropriate to developmental level;
 - c. A lack of spontaneous seeking to share enjoyment, interests or achievement with other people; or
 - d. Lack of social or emotional reciprocity.
 - 2. Qualitative impairments in communications as manifested by at least one (1) of the following:
 - a. Delay in, or total lack of, the development of spoken language;
 - b. In individuals with adequate speech, marked impairment in the ability to imitate or sustain a conversation with others;
 - c. Stereotyped and repetitive use of language or idiosyncratic language; or
 - d. Lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental levels.
 - 3. Restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one (1) of the following:
 - a. Encompassing preoccupation with one (1) or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus;
 - b. Apparently inflexible adherence to specific, nonfunctional routines or rituals;
 - c. Stereotyped and repetitive motor mannerisms; or
 - d. Persistent preoccupation with parts or objects.
- (B) Delays or abnormal functioning in at least one (1) of the following areas, with onset prior to age three (3) years;
 - 1. Social interaction;
 - 2. Language as used in social communication; or
 - 3. Symbolic or imaginative play; and
- (C) The disturbance is not better accounted for by Rett's Disorder or Childhood Disintegrative Disorder.

B

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

DEFINITIONS (continued)

Bariatric services means the *bariatric surgery* and the post-discharge *services* and expenses related to complications following an approved *bariatric surgery*.

Bariatric surgery means gastrointestinal *surgery* to promote weight loss for the treatment of *morbid obesity*.

Behavioral health means *mental health services* and *substance abuse services*.

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

Benefit reductions means the amount by which payment for *covered services* will be reduced if the *covered person* fails to comply with the *plan delivery system rules*.

Bodily injury means bodily damage other than a *sickness*, including all related conditions and recurrent symptoms. However, bodily damage resulting from infection or muscle strain due to athletic or physical activity is considered a *sickness* and not a *bodily injury*.

C

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

Capitation fee means the fixed monthly fee paid to designated *providers* for specified *covered services*. This fee is included in the monthly *premium* rates.

Certified surgical assistant means a *certified surgical assistant* or certified first assistant who is certified by the National Surgical Assistant Association on the Certification of Surgical Assistants, the Liaison Council on Certification of Surgical Technologists, or the American Board of Surgical Assistants. The *certified surgical assistant* is an unlicensed health care *provider* who is directly accountable to a *physician* licensed pursuant to the provisions of KRS 311 or, in the absence of a *physician*, to a registered nurse licensed pursuant to the provisions of KRS Chapter 314.

Childhood obesity, for the purpose of this definition, means a child between the ages of 3 and 18 in the 85th percentile or greater of BMI for their age.

Claim means a request by a *covered person* for payment of a benefit under the plan, including *hospital*, medical/surgical, and *mental health/substance abuse services*, prescription drugs, and other *services* and supplies.

Claimant means a *covered person* (or authorized representative) who files a *claim*.

COBRA Service Provider means a *provider* of COBRA administrative services retained by Humana or the *employer* to provide specific COBRA administrative services.

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

DEFINITIONS (continued)

Complications of pregnancy means:

1. Conditions whose diagnoses are distinct from pregnancy but adversely affected by pregnancy or caused by pregnancy. Such conditions include: acute nephritis, nephrosis, cardiac decompensation, hyperemesis gravidarum, puerperal infection, toxemia, eclampsia and missed abortion;
2. A non-elective cesarean section surgical procedure;
3. Terminated ectopic pregnancy; or
4. Spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.

Complications of pregnancy do not mean:

1. False labor;
2. Occasional spotting;
3. Prescribed rest during the period of pregnancy;
4. Conditions associated with the management of a difficult pregnancy but which do not constitute distinct *complications of pregnancy*; or
5. An elective cesarean section.

Concurrent care decision means a decision by this *Plan* to reduce or terminate benefits otherwise payable for a course of treatment that has been approved by this *Plan* (other than by *Plan* amendment or termination) or a decision with respect to a request by a *claimant* to extend a course of treatment beyond the period of time or number of treatments that has been approved by this *Plan*.

Concurrent review means the process of assessing the continuing *medical necessity*, appropriateness, or utility of additional days of *hospital confinement*, *outpatient care*, and other health care *services*.

Confinement or ***confined*** means *you* are admitted as a registered bed patient in a *hospital* or a *qualified treatment facility* as the result of a *qualified practitioner's* recommendation. It does not mean detainment in observation status.

Contract means the agreement between the Commonwealth and the carrier consisting of the RFP and any addenda, the carrier's proposal and any addenda acceptable to the Commonwealth, any written questions and answers drafted to clarify the proposal, any written master policy between the parties, including the *Summary Plan Description*, and the Division of Purchases MARS document.

Contract year means the year commencing on January 1 and ending on December 31 of each year. For the purposes of this SPD, the terms "*contract year*" and "*plan year*" are interchangeable.

Copayment means a specified amount the *covered person* must pay at the time *services* are rendered for certain *covered services*.

DEFINITIONS (continued)

Cosmetic surgery means *surgery* performed to reshape structures of the body in order to change *your* appearance or improve self-esteem.

Couple coverage means coverage for the *member* and his/her eligible covered *spouse*.

Court-ordered means involuntary placement in *behavioral health* treatment as a result of a judicial directive.

Coverage denial means the *Plan Manager* (Humana) determined that a service, treatment, drug, or device is specifically limited or excluded under *your Plan*.

Coverage level means coverage for the *member* and his/her eligible covered *spouse*.

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

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

Custodial care means *services* provided to assist in the activities of daily living which are not likely to improve *your* condition. Examples include, but are not limited to, assistance with dressing, bathing, preparation and feeding of special diets, transferring, walking, taking medication, getting in and out bed and maintaining continence. These *services* are considered *custodial care* regardless if a *qualified practitioner* or *provider* has prescribed, recommended or performed the *services*.

D

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

Dental injury means an injury to a *sound natural tooth* caused by a sudden, violent, and external force that could not be predicted in advance and could not be avoided.

Dependent means the following:

1. Spouse - a person of the opposite sex to whom you are legally married.
2. Common Law Spouse - a person of the opposite sex with whom you have established a Common Law union **in a state which recognizes Common Law marriage** (Kentucky does not recognize Common Law Marriage).
3. Child Age 0 to 18 - in the case of a child who has not yet attained his/her 19th birthday, "child" means an individual who is:
 - a. A son, daughter, stepson, or stepdaughter of the *employee/retiree*, or
 - b. An eligible foster child of the *employee/retiree* (eligible foster child means an individual who is placed with the *employee/retiree* by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction), or

DEFINITIONS (continued)

- c. An adopted child of the *employee/retiree* (a legally adopted individual of the *employee/retiree*, or an individual who is lawfully placed with the *employee/retiree* for legal adoption by the *employee/retiree*, shall be treated as a child), or
- 4. Child Age 19 to 25 - in the case of a child who has attained his/her 19th birthday but who has not yet attained his/her 26th birthday, "child" means an individual who is:
 - a. A son, daughter, stepson, stepdaughter, eligible foster child, or a adopted child as described above; and
- 5. Disabled Dependent - A *dependent* child who is totally and permanently disabled may be covered on your KEHP benefit plan beyond the end of the month in which he/she turns 26, provided the disability (a) started before his/her 26th birthday and (b) is medically-certified by a physician. A *dependent* child will be considered totally and permanently disabled if, in the judgment of KEHP, the written certification adequately demonstrates that the *Dependent* child is unable to engage in any substantial gainful activity by reason of medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months.

PLEASE NOTE:

A Cross Reference Payment Option is a payment option involving two employees/retirees who are a legally married couple and enroll themselves and at least one child as a dependent in a KEHP family plan.

A dependent must meet KEHP's eligibility rules before an employee/plan holder may add the dependent to the Plan. Upon reaching age of termination the dependent child will become ineligible and be terminated as a dependent at the end of the month in which the birthday occurs.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. This includes adding a dependent to the Plan who does not meet the KEHP eligibility rules.

The KEHP requires documentation to verify a dependent's eligibility before coverage will be provided under the Plan. Examples of such documentation include but are not limited to marriage certificate, birth certificate, court documents and/or guardianship papers.

The health care reform law (Patient Protection and Affordable Care Act) generally requires group health plans that offer dependent coverage to continue making such coverage available for an adult child until age 26.

DEFINITIONS (continued)

In general, a dependent under the KEHP for purposes of accident or health coverage is a dependent as defined as in Code § 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof, (2) any child (as defined in Code § 152(f)(1)) of the Participant who as of the end of the taxable year has not attained age 27, and (3) any child of the Participant to whom IRS Rev. Proc. 2008-48 applies (regarding certain children of divorced or separated parents who receive more than half of their support for the calendar year from one or both parents and are in the custody of one or both parents for more than half of the calendar year). Because this plan is “grandfathered”, this plan is not required to extend coverage to children who are eligible for coverage under another employer’s group health plan (*e.g.*, eligible under the plan of the child’s own employer). This plan has interpreted this to mean the child full-time employer. A “grandfathered” plan cannot deny coverage if a child is eligible for coverage under another *parent’s* group health plan, however.

A “child” is an individual who is the employee’s son, daughter, stepson, or stepdaughter, and includes both a legally adopted individual of the employee and an individual lawfully placed with the employee for legal adoption by the employee. The term “child” also includes an eligible foster child, defined as a child placed with the employee by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

The definition change the age limit, residency, support, and other tests that would otherwise have to be met in order for an individual to qualify as a tax dependent under the Code do not apply to such an employee’s child for purposes of the tax-favored treatment of health coverage that is available under Code §§ 105(b) and 106.

The status as a “qualifying child” or “qualifying relative” under Section 152 will continue to be relevant when determining the tax treatment of health coverage for individuals who are not an employee’s spouse or child.

Individuals under a civil union or domestic partnership are not eligible for coverage under this plan. Dependent status between a Participant and dependent or other individual must not violate federal, state or local law.

Diabetes equipment means blood glucose monitors, including monitors designed to be used by blind individuals, insulin infusion pumps and associated accessories, insulin infusion devices and podiatric appliances for the prevention of complications associated with diabetes.

Diabetes self-management training means the training provided to a *covered person* after the initial diagnosis of diabetes for care and management of the condition including nutritional counseling and use of *diabetes equipment* and supplies. It also includes training when changes are required to the self-management regime and when new techniques and treatments are developed.

Diabetes supplies means test strips for blood glucose monitors, visual reading and urine test strips, lancets and lancet devices, insulin and insulin analogs, injection aids, syringes, prescriptive and non-prescriptive oral agents for controlling blood sugar levels, glucagon emergency kits and alcohol swabs.

Diagnostic Admission means an *admission* of an *inpatient* that does not require the constant availability of medical supervision or *skilled nursing care* to monitor a condition. The primary purpose of such *admission* is to arrive at a diagnosis through the use of x-ray and laboratory tests, consultations, and evaluation, as documented by the *hospital’s* medical records, these *diagnostic services* could be provided on an *outpatient* basis to determine the need for treatment.

DEFINITIONS (continued)

Diagnostic Service means a test or procedure rendered because of specific symptoms and which is directed toward the determination of a definite condition or disease. A *diagnostic service* must be ordered by a *physician* or other professional *provider*.

Durable medical equipment (DME) means equipment that is *medically necessary* and able to withstand repeated use. It must also be primarily and customarily used to serve a medical purpose and not be generally useful to a person except for the treatment of a *bodily injury* or *sickness*.

E

Effective date means the date on which coverage for a *covered person* begins.

Eligible class means performing on a regular, full-time basis all customary occupational duties, as determined by the *employer*, at the *employer's* business locations or when required to travel for the *employer's* business purposes. An *employee* shall be deemed at work on each day of a regular paid vacation and any regular non-working holiday.

Eligible person means a person who meets the eligibility requirements of the *Kentucky Employees' Health Plan*.

Eligible Expense means a *provider's* fee which:

1. Is the *provider's* usual charge for a given service under the *covered person's* plan;
2. Is within the range of fees charged by *providers* of similar training and experience for the same or similar service or supply within the same or similar limited geographic area; and
3. Does not exceed the fee schedule developed by the carrier for a network *provider*.

The terms "*eligible expense*" and "reasonable and customary charge" are interchangeable.

Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain that a prudent layperson would reasonably have cause to believe constitutes a condition that the absence of immediate medical attention could reasonably be expected to result in: (a) placing the health or the individual or with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.

With respect to a pregnant woman who is having contractions: (a) a situation in which there is inadequate time to effect a safe transfer to another *hospital* before delivery; or (b) a situation in which transfer may pose a threat to the health or safety of the woman or the unborn child.

Employee means a person who is employed by agencies participating in the *Kentucky Employees' Health Plan* and eligible to apply for coverage under a *Kentucky Employees' Health Plan* or who is a *retiree* of a state sponsored Retirement System Health Plan. Refer to KRS 18A.225 and KRS 18A.227.

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

Enrollment date means the first (1st) day of coverage of a *member* and his/her eligible *dependents* under the certificate, or, if there is a *waiting period*, the first day of the *waiting period* (typically the date employment begins).

DEFINITIONS (continued)

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

Experimental, investigational or for research purposes:

Services, supplies, or other care, including treatments, procedures, hospitalizations, drugs, biological products or medical devices, which a Peer Review Panel determines are:

1. Not of proven benefit for the particular diagnosis or treatment of the *covered person's* particular condition;
2. Not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of the *covered person's* particular condition; or
3. Provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the United States Food and Drug Administration (FDA), the plan shall not cover any *services* or supplies, including treatment, procedures, drugs, biological products or medical devices or any hospitalization in connection with *experimental or investigational services* or supplies. The plan shall not cover any technology or any hospitalization in connection with such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of the *covered person's* particular condition. Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of the particular condition as explained below.

The carrier shall apply the following five (5) criteria in determining whether *services* or supplies are *experimental or investigational*:

1. Any medical device, drug, or biological product must have received final approval to market by the FDA for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug, or biological product for another diagnosis or condition shall require that one or more of the following established reference compendia: (1) the American Medical Association Drug Evaluations; (2) the American Hospital Formulary Service Drug Information; or (3) the United States Pharmacopoeia Drug Information, recognize the usage as appropriate medical treatment. As an alternative to such recognition in one (1) or more of the compendia, the usage of the drug shall be recognized as appropriate if it is recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal. A medical device, drug, or biological product that meets the above tests shall not be considered *experimental or investigational*. In any event, any drug which the FDA has determined to be contraindicated for the specific treatment for which the drug has been prescribed shall be considered *experimental or investigational*.
2. Conclusive evidence from the published peer-review medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;

DEFINITIONS (continued)

3. Demonstrated evidence as reflected in the published peer-review medical literature must exist that over time the technology leads to improvement in health outcomes, e.g., the beneficial effects outweigh any harmful effects;
4. Proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and
5. Proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph C, are possible in standard conditions of medical practice, outside clinical investigatory settings.

F

Family coverage means coverage for the *member*, the *member's spouse* under an existing legal marriage, and one (1) or more *dependent* children.

Family maximum deductible means the total sum of *eligible expenses* applied toward the *deductible* for persons covered under a *member's* plan.

Freestanding renal dialysis facility means a *provider* other than a *hospital* which is primarily engaged in providing renal dialysis treatment, maintenance or training to *outpatients*.

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

Final external review decision means a determination by an *independent review organization* at the conclusion of an *external review*.

Final internal adverse benefit determination means an *adverse benefit determination* that has been upheld by this Plan at the completion of the *internal appeals* process (or an *adverse benefit determination* with respect to which the internal *appeals* process has been exhausted under the deemed exhaustion rules).

Functional impairment means a direct and measurable reduction in physical performance of an organ or body part.

H

Hazardous duty retiree means a *retiree* in (a) any position whose principal duties involve active law enforcement, including the positions of probation and parole officer and Commonwealth detective, active fire suppression or prevention, or other positions, including, but not limited to, pilots of the Transportation Cabinet and paramedics and *Emergency Medical Technicians*, with duties that require frequent exposure to a high degree of danger or peril and also require a high degree of physical conditioning, and (b) positions in the Department of Corrections in state correctional institutions and the Kentucky Correctional Psychiatric Center with duties that regularly and routinely require face-to-face contact with inmates.

DEFINITIONS (continued)

Hearing aids means any wearable, non-disposable instrument or device designed to aid or compensate for impaired human hearing and any parts, attachments, or accessories, including ear molds, excluding batteries and cords. In addition, *services* necessary to assess, select, and appropriately adjust or fit the *hearing aid* to ensure optimal performance.

Home Health Agency means an agency that provides intermittent skilled nursing and health related *services* to patients in their homes under a treatment plan prescribed by a *physician*. The agency must be licensed as a *Home Health Agency* by the state in which it operates or be certified to participate in *Medicare* as a *Home Health Agency*.

Hospice means a *provider*, other than a facility that treats *inpatients*, which is primarily engaged in providing pain relief, symptom management, and supportive *services* to terminally ill persons and their families. The facility must be operated in accordance with the laws of the jurisdiction in which it is located.

Hospital means an institution which:

1. Maintains permanent full-time facilities for bed care of resident patients;
2. Has a physician and surgeon in regular attendance;
3. Provides continuous 24 hour a day nursing *services* by, or under the supervision of, registered nurses;
4. Is primarily engaged in providing diagnostic and therapeutic facilities for medical or surgical care of sick or injured persons under the supervision of a staff of fully licensed *physicians*. No *claim* for payment of treatment, care, or *services* shall be denied because a *hospital* lacks major surgical facilities and is primarily of a rehabilitative nature, if such rehabilitation is specifically for treatment of physical disability;
5. Is legally operated in the jurisdiction where located; and
6. Has surgical facilities on its premises or has a contractual agreement for surgical *services* with an institution having a valid license to provide such surgical *services*; or
7. It is a *hospital* accredited by the Joint Commission on the Accreditation of Healthcare Organizations, the American Osteopathic Association, or the Commission on the Accreditation of Rehabilitative Facilities, or certified by the Kentucky Division of Licensure and Regulation.

Hospital does not include an institution which is principally a rest home, skilled nursing facility, convalescent home or home for the aged. *Hospital* does not include a place principally for the treatment of *mental health* or *substance abuse*.

I

Independent review organization (or IRO) means an entity that conducts independent *external reviews* of *adverse benefit determinations* and *final internal adverse benefit determinations*..

Independent panel means a separate review agency responsible for Utilization Management determination.

DEFINITIONS (continued)

Informed Care Management Program means a coordinated system of preventive, diagnostic, and therapeutic measures intended to provide cost-effective, quality healthcare for a patient population who have or are at risk for a specific chronic illness or medical condition.

Inpatient means a *covered person* who is treated as a registered bed patient in a *hospital* or other institutional *provider* and for whom a room and board charge is made.

Intensive outpatient means *outpatient services* providing:

1. Group therapeutic sessions greater than one hour a day, three days a week;
2. *Behavioral health* therapeutic focus;
3. Group sessions centered on cognitive behavioral constructs, social/occupational/educational skills development and family interaction;
4. Additional emphasis on recovery strategies, monitoring of participation in 12-step programs and random drug screenings for the treatment of *substance abuse*; and
5. *Qualified practitioner* availability for medical and medication management.

Intensive outpatient program does not include services that are for:

1. *Custodial care*; or
2. Day care.

K

Kentucky Employees' Health Plan means the group which is composed of eligible *employees* of state agencies, boards of education, local health departments, quasi agencies, the Kentucky Community and Technical College System, *retiree* (as defined in this Section) of the Kentucky Retirement Systems, Kentucky Teachers' Retirement System, the Legislators Retirement Plan, and the Judicial Retirement Plan, and their eligible *dependents*. This *Plan* may also be referred to as the Public Employee Health Insurance Program.

L

Late applicant means an *employee* and/or an *employee's* eligible *dependent* who applies for medical coverage more than 35 days after the eligibility date. An individual shall not be considered a late enrollee if: (a) the person enrolls during his/her initial enrollment period; (b) the person enrolls during any annual open enrollment period; or (c) the person enrolls during a *Special Enrollment period*.

DEFINITIONS (continued)

M

Maintenance care means any *service* or activity which seeks to prevent *bodily injury* or *sickness*, prolong life, promote health or prevent deterioration of a *covered person* who has reached the maximum level of improvement or whose condition is resolved or stable.

Maximum allowable fee for a *covered expense* is the lesser of:

1. The fee charged by the *provider* for the *services*;
2. The fee that has been negotiated with the *provider* whether directly or through one or more intermediaries or shared savings contracts for the *services*;
3. The fee established by this *Plan* by comparing rates from one or more regional or national databases or schedules for the same or similar *services* from a geographical area determined by this *Plan*;
4. The fee based upon rates negotiated by this *Plan* or other payors with one or more *participating providers* in a geographic area determined by this *Plan* for the same or similar *services*;
5. The fee based upon the *provider's* cost for providing the same or similar *services* as reported by such *provider* in its most recent publicly available *Medicare* cost report submitted to the Centers for *Medicare* and Medicaid Services (CMS) annually; or
6. The fee based on a percentage determined by this *Plan* of the fee *Medicare* allows for the same or similar *services* provided in the same geographic area.

Note: The bill you receive for *services* from *non-participating providers* may be significantly higher than the *maximum allowable fee*. In addition to *deductibles*, *copayments* and *coinsurance*, you are responsible for the difference between the *maximum allowable fee* and the amount the *provider* bills you for the *services*. Any amount you pay to the *provider* in excess of the *maximum allowable fee* will not apply to your *out-of-pocket limit* or *deductible*.

Maximum benefit means the maximum amount that may be payable for each *covered person*, for *expense incurred*. The applicable *maximum benefit* is shown in the Schedule of Benefits section. No further benefits are payable once the *maximum benefit* is reached.

Medically necessary or medical necessity means the extent of *services* required to diagnose or treat a *bodily injury* or *sickness* which is known to be safe and effective by the majority of *qualified practitioners* who are licensed to diagnose or treat that *bodily injury* or *sickness*. Such *services* must be:

1. Performed in the least costly setting required by *your* condition;
2. Not provided primarily for the convenience of the patient or the *qualified practitioner*;
3. Appropriate for and consistent with *your* symptoms or diagnosis of the *sickness* or *bodily injury* under treatment;
4. Furnished for an appropriate duration and frequency in accordance with accepted medical practices, and which are appropriate for *your* symptoms, diagnosis, *sickness* or *bodily injury*; and
5. Substantiated by the records and documentation maintained by the *provider* of *service*.

DEFINITIONS (continued)

Medicare means a program of medical insurance for the aged and disabled, as established under Title 18 of the Social Security Act of 1965, as amended.

Member means an *employee, Retiree, or COBRA participant* who is covered by one (1) of the health plans offered by the *Kentucky Employees' Health Plan*.

Mental health means a mental, nervous, or emotional disease or disorder of any type as classified in the Diagnostic and Statistical Manual of Mental Disorders, regardless of the cause or causes of the disease or disorder.

Mental health condition means a condition that manifests symptoms, which are primarily mental or nervous, regardless of any underlying physical cause. A *mental health condition* includes, but is not limited to, psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders e.g., attention deficit disorder, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

In determining whether or not a particular condition is a *mental health condition*, the carrier may refer to the current edition of the Diagnostic and Statistical Manual of Mental Conditions (DSM) of the American Psychiatric Association, or the International Classification of Diseases (ICD) manual.

Morbid obesity (clinically severe obesity) means a body mass index (BMI) as determined by a *qualified practitioner* as of the date of *service* of:

1. 40 kilograms or greater per meter squared (kg/m^2); or
2. 35 kilograms or greater per meter squared (kg/m^2) with an associated comorbid condition such as hypertension, type II diabetes, life-threatening cardiopulmonary conditions; or joint disease that is treatable, if not for the obesity.

N

Non-participating (Non-PAR) provider means a *hospital, qualified treatment facility, qualified practitioner* or any other health *services provider* who has not entered into an agreement with the *Plan Manager* (Humana) to provide *participating provider services* or has not been designated by the *Plan Manager* (Humana) as a *participating provider*.

Nursing Facility means a *provider*, which is primarily engaged in providing skilled, nursing care and related *services* to an *inpatient* requiring convalescent and rehabilitative care. Such care must be rendered by or under the supervision of a *physician* and eligibility for payment is based on care rendered in compliance with *Medicare*-established guidelines. The facility must be operated in accordance with the laws of the jurisdiction in which it is located. A *nursing facility* is not, other than incidentally, a place that provides: (a) minimal care, *custodial care*, ambulatory care, or part-time care *services*; and (b) Care or treatment of *mental health conditions*, alcoholism, drug abuse, or pulmonary tuberculosis.

O

Off-evidence drug indications mean indications for which there is a lack of sufficient evidence for safety and/or efficacy for a particular medication.

DEFINITIONS (continued)

Off-label drug indications mean prescribing of an FDA-approved medication for a use or at a dose that is not included in the product indications or labeling. This term specifically refers to drugs or dosages used for diagnoses that are not approved by the FDA and may or may not have adequate medical evidence supporting safety and efficacy. Off-label prescribing of traditional drugs is a common clinical practice and many off-label uses are effective, well documented in peer reviewed literature and widely employed as standard of care treatments.

Orthotic means a fitted or custom-made brace, splint, cast, support or other device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body when prescribed by a *qualified practitioner*.

Out-of-pocket limit is a specified dollar amount that must be satisfied, either individually or combined as a covered family, per *calendar year* before a benefit percentage will be increased. Any *deductible* amount, all *copayments* under this medical SPD where applicable, will be included in the out-of-pocket maximum. When the *out-of-pocket limit* is reached, *coinsurance* ceases for those *covered services* specified in the schedule of benefits. It does not include any amounts not paid because a *maximum benefit* limit has been reached, or any amount above an *eligible expense*.

Outpatient means a *covered person* who receives *services* or supplies while not an *inpatient*.

P

Parent Plus Coverage means coverage for the *member* and eligible *dependents* except the *spouse*.

Partial hospitalization means *services* provided by a *hospital* or *qualified treatment facility* in which patients do not reside for a full 24-hour period:

1. For a comprehensive and intensive interdisciplinary psychiatric treatment for minimum of 5 hours a day, 5 days per week;
2. That provides for social, psychological and rehabilitative training programs with a focus on reintegration back into the community and admits children and adolescents who must have a treatment program designed to meet the special needs of that age range; and
3. That has physicians and appropriately licensed *mental health* and *substance abuse* practitioners readily available for the emergent and *urgent care* needs of the patients.

The *partial hospitalization* program must be accredited by the Joint Commission of the Accreditation of Hospitals or in compliance with an equivalent standard.

Licensed drug abuse rehabilitation programs and alcohol rehabilitation programs accredited by the Joint Commission on the Accreditation of Health Care Organizations or approved by the appropriate state agency are also considered to be *partial hospitalization services*.

Partial hospitalization does not include *services* that are for *custodial care* or day care.

Participating (PAR) provider means a *hospital*, *qualified treatment facility*, *qualified practitioner* or any other health *services provider* who has entered into an agreement with, or has been designated by, Humana to provide specified *services* to all *covered persons*.

DEFINITIONS (continued)

Pay period means the 15th of the month or the last day of the month. This term may also be called semi-monthly billing cycle.

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

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

Physician assistant means a person who has graduated from a *physician* assistant or surgeon assistant program accredited by the American Medical Association's Committee on Allied Health Education and Accreditation or the Commission on Accreditation of Allied Health Education Programs and who has passed the certifying examination administered by the National Commission on Certification of *Physician* Assistants or who possesses a current *physician* assistant certificate issued by the board prior to July 15, 1998.

Plan means the health care plan or plans sponsored and maintained by the *Kentucky Employees' Health Plan* with respect to which benefits are provided to *covered persons* under this certificate.

Plan Administrator means Commonwealth of Kentucky.

Plan Delivery System Rules means the specific procedures and/or terminology established by a carrier that must be followed to obtain *maximum benefits* for *covered services* under the plan.

Plan Manager means Humana Insurance Company (HIC). The *Plan Manager* provides services to the *Plan Administrator*, as defined under the Plan Management Agreement. The *Plan Manager* is not the *Plan Administrator* or the *Plan Sponsor*.

Plan Sponsor means Commonwealth of Kentucky.

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

Post-service claim means any *claim* for a benefit under a group health plan that is not a *pre-service claim*.

Preadmission testing means only those *outpatient* x-ray and laboratory tests made within seven days before *admission* as a registered bed patient in a *hospital*. The tests must be for the same *bodily injury* or *sickness* causing the patient to be *hospital confined*. The tests must be accepted by the *hospital* in lieu of like tests made during *confinement*. *Preadmission testing* does not mean tests for a routine physical check-up.

Precertification (also known as "*preauthorization*") means the process of assessing the *medical necessity*, appropriateness, or utility of proposed non-emergency *hospital admissions*, surgical procedures, *outpatient* care, and other health care *services*.

Predetermination of benefits means a review by Humana of a *qualified practitioner's* treatment plan, specific diagnostic and procedure codes and expected charges prior to the rendering of *services*.

Premium means the periodic charges due which the *member*, or the *member's* group, must pay to maintain coverage.

Premium Due Date means the date on which a *premium* is due to maintain coverage under this certificate.

DEFINITIONS (continued)

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

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

Pre-service claim means a *claim* with respect to which the terms of the *Plan* condition receipt of a *Plan* benefit, in whole or in part, on approval of the benefit by Humana in advance of obtaining medical care.

Primary Care Physician means a network *provider* who is a practitioner specializing in family practice, general practice, internal medicine, or pediatrics who supervises, coordinates and provides initial care and basic medical *services* to a *covered person*, initiates the *covered person's* referral for specialist *services*, and is responsible for maintaining continuity of patient care.

Protected health information means individually identifiable health information about a *covered person*, including: (a) patient records, which includes but is not limited to all health records, physician and *provider* notes and bills and *claims* with respect to a *covered person*; (b) patient information, which includes patient records and all written and oral information received about a *covered person*; and (c) any other individually identifiable health information about *covered persons*.

Provider means a facility or person, including a *hospital* or *physician*, which is licensed, where required, to render *covered expenses*. *Providers* other than a *hospital* or *physician*, including a Doctor of Osteopathy, include, but not limited to:

Ambulatory Care Facility	Licensed Psychological Associate
Birthing Center	Licensed Psychological Practitioner
<i>Certified Surgical Assistant</i>	Licensed Clinical Social Worker
<i>Freestanding Renal Dialysis Facility</i>	Licensed Physical Therapist
<i>Home Health Agency</i>	Licensed Practical Nurse
<i>Hospice</i>	Licensed Speech Pathologist
<i>Psychiatric Facility</i>	Licensed Speech Therapist
<i>Nursing Facility</i>	Licensed Occupational Therapist
<i>Substance Abuse Treatment Facility</i>	Licensed Pharmacist
Advanced Registered Nurse Practitioner	Midwife
Doctor of Chiropractic	Registered Nurse
Doctor of Dental Medicine	<i>Registered Nurse First Assistant</i>
Doctor of Dental <i>Surgery</i>	<i>Physician Assistant</i>
Doctor of Optometry	Respiratory Therapist
Doctor of Podiatry	Certified Psychologist
Doctor of Surgical Chiropody	Certified Psychological Associate
Licensed Psychologist	Ophthalmic Dispenser

DEFINITIONS (continued)

Psychiatric Facility means a *provider* primarily engaged in providing diagnostic and therapeutic *services* for the treatment of *mental health conditions*. The facility must be operated in accordance with the laws of the jurisdiction in which it is located and provide treatment by or under the care of *physicians* and nursing *services* whenever the patient is in the facility.

Q

Qualified beneficiary means any individual who, on the day before a COBRA *qualifying event*, is covered under the plan by virtue of being on that day a *covered person*, or any child who is born or placed for adoption with a *member* during a period of COBRA continuation coverage.

Qualified practitioner means a practitioner, professionally licensed by the appropriate state agency to diagnose or treat a *bodily injury* or *sickness*, and who provides *services* within the scope of that license.

Qualified treatment facility means only a facility, institution or clinic duly licensed by the appropriate state agency, and is primarily established and operating within the scope of its license.

Qualifying event means a specific situation or occurrence that enables an *eligible person* to enroll or disenroll outside the designated enrollment period as a result of that person becoming eligible for or losing eligibility for coverage under this group plan or another group plan. *Qualifying events* are governed by 26 C.F.R. § 1.125-4 and Prop.Treas. Reg 1.125-2(a). All applications for *qualifying events* must be signed within 35 days of the *qualifying event* date.

R

Registered Nurse First Assistant means a nurse who:

1. Holds a current active registered nurse licensure;
2. Is certified in perioperative nursing; and
3. Has successfully completed and holds a degree or certificate from a recognized program, which shall consist of: (a) the Association of Operating Room Nurses, Inc., Core Curriculum for the *registered nurse first assistant*; and (b) one (1) year of post basic nursing study, which shall include at least forty-five (45) hours of didactic instruction and 140 hours of clinical internship or its equivalent of two (2) college semesters.

A registered nurse who was certified prior to 1995 by the Certification Board of Perioperative Nursing shall not be required to fulfill the requirements of paragraph (3) of this subsection.

Rehabilitation Center means a facility which provides *services* of non-acute rehabilitation. All *services* are provided under the direction of a psychiatrist, a medical doctor with a specialty in rehabilitation and physical medicine. The facility is staffed around the clock by registered nurses and it does not provide *services* of a custodial nature. The facility must be *Medicare* certified licensed by the State Department of Health as a “special *hospital*” and accredited by the Joint Commission on Accreditation of Healthcare Organizations. It is also accredited by the Commission on Accreditation of Rehabilitation Facilities.

DEFINITIONS (continued)

Residential treatment facility means an institution which:

1. Is licensed as a 24-hour residential facility for *mental health* and *substance abuse* treatment, although not licensed as a *hospital*;
2. Provides a multidisciplinary treatment plan in a controlled environment, with periodic supervision of a physician or a Ph.D. psychologist; and
3. Provides programs such as social, psychological and rehabilitative training, age appropriate for the special needs of the age group of patients, with focus on reintegration back into the community.

Residential treatment is utilized to provide structure, support and reinforcement of the treatment required to reverse the course of behavioral deterioration.

Respite Care means care that is necessary to provide temporary relief from caregiving responsibilities, to support caregivers who are actively involved in providing the care required by a *covered person*, and whose continuing support is necessary to maintain the individual at home.

Retiree means a *covered person* of a retirement plan administered by the Kentucky Retirement Systems, Kentucky Teachers' Retirement System, Kentucky Legislators' Retirement Plan, Kentucky Judicial Retirement Plan or any other state sponsored retirement system, who is under age sixty-five (65) or is age 65 or older and is non *Medicare* eligible.

S

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

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

Single coverage means coverage for the *member* only.

Skilled Nursing Care means *services*, supplies, or other care needed for medical conditions that require treatment by skilled medical personnel such as registered nurses or professional therapists. Care must be available twenty-four (24) hours per day, be ordered by a *physician*, and usually involves a treatment plan designed specifically for each patient.

Sound natural tooth means a tooth that:

1. Is organic and formed by the natural development of the body (not manufactured);
2. Has not been extensively restored;
3. Has not become extensively decayed or involved in periodontal disease; and
4. Is not more susceptible to injury than a whole natural tooth.

DEFINITIONS (continued)

Special enrollment period means a period of time during which an *eligible person* or *dependent* who loses other health insurance coverage or incurs a change in status may enroll in the plan without being considered a *late enrollee*.

Spouse means a person married to the *member* under an existing legal marriage.

Specialty drug means a drug, medicine or medication used as a specialized therapy developed for chronic, complex *sicknesses* or *bodily injuries*. *Specialty drugs* may:

1. Require nursing services or special programs to support patient compliance;
2. Require disease-specific treatment programs;
3. Have limited distribution requirements; or

Have special handling, storage or shipping requirements.

Substance abuse means the abuse of, or psychological or physical dependence on, or addiction to alcohol or a controlled substance.

Substance Abuse Treatment Facility means a *provider* that is primarily engaged in providing detoxification and rehabilitation treatment for *substance abuse*. The facility must be operated and licensed in accordance with the laws of the jurisdiction in which it is located and provide treatment by or under the care of *physicians* and nursing *services* whenever the patient is in the facility.

Summary Plan Description (SPD) means this document which outlines the benefits, provisions and limitations of this *Plan*.

Surgery means excision or incision of the skin or mucosal tissues, or insertion for exploratory purposes into a natural body opening. This includes insertion of instruments into anybody opening, natural or otherwise, done for diagnostic or other therapeutic purposes.

T

Telehealth services mean- the use of interactive audio, video, or other electronic media to deliver health care. It includes the use of electronic media for diagnosis, consultation, treatment, transfer of medical data, and medical education. A telehealth consultation shall not be reimbursable if it is provided through the use of an audio-only telephone, facsimile machine, or electronic mail.

DEFINITIONS (continued)

Therapy Service means *services*, supplies, or other care used for the treatment of a *sickness* or *bodily injury* to promote the recovery of the patient. *Therapy services* include, but are not limited to:

1. Physical Therapy – The treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, biomechanical and neurophysiological principles and devices to relieve pain, restore maximum function, and prevent disability following disease, *bodily injury* or loss of a body part.
2. Respiratory Therapy – Introduction of dry or moist gases into the lungs for treatment purposes.
3. Speech Therapy – The treatment rendered to gain speech loss due to *sickness* or *bodily injury*, or as a result of complications at birth, congenital anomaly, or previous medical treatment.
4. Cardiac Rehabilitation – Treatment provided to individuals who have suffered a heart attack, have had heart *surgery*, or have other cardiac problems.
5. Occupational Therapy – The treatment program of prescribed activities coordination and mastery, designed to assist a person to gain independence, particularly in the normal activities of daily living.

Timely applicant means an *employee* and/or an *employee's* eligible *dependent* who applies for medical coverage within 35 days of the eligibility date.

Total disability or totally disabled means:

1. During the first twelve months of disability *you* or *your* employed covered *spouse* are at all times prevented by *bodily injury* or *sickness* from performing each and every material duty of *your* respective job or occupation;
2. After the first twelve months, *total disability* or *totally disabled* means that *you* or *your* employed covered *spouse* are at all times prevented by *bodily injury* or *sickness* from engaging in any job or occupation for wage or profit for which *you* or *your* employed covered *spouse* are reasonably qualified by education, training or experience;
3. For a non-employed *spouse* or a child, *total disability* or *totally disabled* means the inability to perform the normal activities of a person of similar age and gender.

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

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

U

Urgent care means *services*, supplies or other care that is appropriate to the treatment of a *sickness* or *injury* that is not a life-threatening *emergency*, but requires prompt medical attention. *Urgent care* includes the treatment of minor injuries as a result of *accidents*, the relief or elimination of severe pain, or the moderation of an acute *illness*.

DEFINITIONS (continued)

Urgent care claim means any claim for medical care or treatment when the time periods for making non-urgent care determinations:

1. Could seriously jeopardize the life or health of the *claimant* or the ability of the *claimant* to regain maximum function; or
2. In the opinion of the physician with knowledge of the *claimant's* medical condition, would subject the *claimant* to severe pain that cannot be adequately managed without the care or treatment recommended.

Utilization review means the process of assessing the *medical necessity*, appropriateness, or utility of *hospital admissions*, surgical procedures, *outpatient* care, and other health care *services*. *Utilization review* includes *precertification* and *concurrent review*.

W

Waiting Period means the period of time before an individual becomes eligible for coverage under the *plan*.

Wellness Program means educational and clinical *services* designed to improve a *member's* health by promoting healthy behaviors, such as eating well, exercising, and assistance in altering unhealthy behaviors.

Y

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

SECTION 7

ADDITIONAL NOTICES

ADDITIONAL NOTICES

NOTICE TO ENROLLEES CONCERNING TOBACCO

Under a Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, as amended, group health plans must generally comply with certain requirements. However, the law also permits state and local governmental employers that sponsor health plans to elect to exempt a plan from these requirements for any part of the plan that is “self-funded” by the employer, rather than provided through a health insurance policy. A group health plan may not discriminate in enrollment rules or in the amount of premiums or contributions it requires an individual to pay based on certain health status-related factors: health status, medical condition (physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability. **The sole differentiation among enrollees in the Commonwealth’s Plan relates to the incentive, through a greater employer contribution, offered to enrollees that refrain from the use of tobacco products. No other health-related factors are used to distinguish enrollees.**

Notice of Privacy Practices

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT
YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET
ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY!**

Effective August 1, 2013

This Notice of Privacy Practices (the “Notice”) describes the legal obligations of the Kentucky Employees’ Health Plan (“KEHP” or “Plan”) and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and subsequent regulations. This Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice of Privacy Practices to you pursuant to HIPAA.

If you have any questions about this Notice or about our privacy practices, please contact: Sharron S. Burton, Deputy Executive Director and Privacy Officer, Office of Legal Services, Personnel Cabinet, 501 High Street, 3rd Floor, Frankfort, Kentucky 40601; Phone: (502) 564-7430; Fax: (502) 564-7603; E-mail: Sharron.Burton@ky.gov.

KEHP Responsibilities

We are required by law to:

- Maintain the privacy of your protected health information;
- Provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information;
- Notify affected individuals following a breach of unsecured protected health information; and
- Abide by the terms of the Notice that is currently in effect.

ADDITIONAL NOTICES

ADDITIONAL NOTICES (continued)

We reserve the right to change the terms of this Notice and to make new notice provisions effective regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will post the change or the revised Notice on the Personnel Cabinet, Department of Employee Insurance website at www.kehp.ky.gov. In addition, notice regarding our privacy practices will be included in the annual open enrollment materials.

What is Protected Health Information?

The HIPAA Privacy Rule protects only certain medical information known as protected health information. **Protected Health Information or PHI** is individually identifiable health information that is transmitted or maintained in electronic media or in any other form or medium. PHI does not include employment records held by an employer acting in their role of employer.

Individually identifiable health information is health information about you, including demographic information such as your name, address, telephone number, or Social Security number. It also includes information that is created or received by a health care provider, a health plan, and employer that relates to your physical or mental health or condition, the provision of health care to you, or the payment of your healthcare.

Permitted Use and Disclosures

Under the law, we may use or disclose your PHI under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your PHI. For each category of uses and disclosures, we will explain what we mean and provide examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the listed categories.

We have the right to use and disclose your PHI:

- **To You or Your Personal Representative** including corresponding with you about your plan and benefits available to you;
- Pursuant to and in compliance with a **Valid Authorization** or an **Agreement** with you;
- **For Treatment**, including the provision, coordination, or management of health care and related services;
- **For Payment**, including activities to collect premiums, to fulfill responsibility for coverage and provide benefits under the health plan, to obtain or provide reimbursement for the provision of health care, to determine eligibility or coverage, to process claims, to adjudicate or subrogate claims, to pay for the treatment and services you receive from health care providers, to carry out collection activities, and to perform utilization review activities such as preauthorization;
- **For Health Care Operations** including conducting quality assessment and improvement, engaging in activities to improve health or reduce health care costs, conducting case management and care coordination, contacting doctors and patients with information about treatment alternatives, reviewing the competence or qualifications of and credentialing health care providers, enrollment activities, premium rating, arranging for medical review and auditing functions, arranging for legal review, fraud and abuse detection programs, resolving internal grievances, providing customer service, business planning and development, and for general Plan administration activities;
- **Incident** to a use or disclosure otherwise permitted by HIPAA;

ADDITIONAL NOTICES (continued)

- **To Business Associates** that create, receive, maintain, or transmit PHI on behalf of KEHP. A Business Associate may provide legal, actuarial, accounting, consulting, data aggregation, management, and administrative services for KEHP. A Business Associate may only disclose your information as permitted or required by its contract with KEHP or as required by law;
- **To Plan Sponsors** including employees who require PHI for the administration of the Plan. These employees will only use or disclose that information necessary to perform Plan administration functions, such as enrollment and termination, or as otherwise required by HIPAA, unless you have authorized further disclosures;
- **An Employer** about an individual who is a member of the workforce of the employer if the PHI that is disclosed consists of findings concerning a work-related illness or injury or a workplace-related medical surveillance; and
- **As Required by Federal, State, or Local Law** and the use or disclosure complies with and is limited to the relevant requirements of such law.

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

Limited Uses and Disclosures:

We may, with certain limitations specified by HIPAA, use and disclose PHI about you:

- **To a Family Member, Relative, Close Personal Friend, Personal Representative or Any Other Person identified by you** provided the disclosure is directly relevant to such persons' involvement with your health care or payment related to your health care;
- **To Notify** or assist in the notification of a family member, your personal representative, or another person responsible for your care regarding your location, general condition, or death;
- **To a Public or Private Entity** authorized by law or by its charter to assist in disaster relief efforts;
- **As Required by Federal, State, or Local Law** and the use or disclosure complies with and is limited to the relevant requirements of such law;
- **For Public Health Activities** including disclosure to a public health authority that is authorized by law to collect or receive PHI for the purpose of preventing or controlling disease, injury, or disability which includes reporting of disease, injury, or vital events such as birth or death, and the conduct of public health surveillance, public health investigations, and public health interventions; to report child abuse or neglect; to collect or report on the quality, safety, or effectiveness of products or activities; to enable product recalls, repairs, or replacements; to notify a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition;
- **To your Employer** if you receive health care at the request of your employer for the evaluation relating to medical surveillance of the workplace or to evaluate whether you have had a work-related illness or injury;
- **To a School** if you are a student or a prospective student of the school and the PHI that is disclosed is limited to proof of immunization, the school is required to have such proof, and you or a personal representative agree to the disclosure;

ADDITIONAL NOTICES (continued)

- **To a Government Authority** if we reasonably believe that you are a victim of abuse, neglect, or domestic violence to the extent the disclosure is required by law, you agree to the disclosure, or the disclosure is expressly authorized by law and we believe the disclosure is necessary to prevent serious harm to you or other potential victims, or you are unable to agree because of incapacity;
- **To a Health Oversight Agency** for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; or other activities necessary for appropriate oversight of the health care system, government benefit programs, government regulatory programs, and determining compliance with civil rights laws;
- **In the Course of any Judicial or Administrative Proceeding** and in response to an order of a court or administrative tribunal, a subpoena, a discovery request, or other lawful process;
- **To Law Enforcement** including instances where you are suspected to be a victim of a crime, or for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person;
- **To a Coroner or Medical Examiner** for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law;
- **To a Funeral Director** as necessary to carry out their duties with respect to the decedent;
- **To Organ Procurement Organizations** or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue and for the purpose of facilitating organ, eye, or tissue donation or transplantation;
- **For Research Purposes** when the individual identifiers have been removed or an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information and approves the research;
- **To Avert a Serious Threat to Health or Safety** and the disclosure is to persons reasonably able to prevent or lessen the threat or is necessary for law enforcement authorities to identify or apprehend an individual;
- **For Military and Veterans Activities or to Federal Officials** for purposes including to assure the proper execution of a military mission, conducting lawful intelligence and counter-intelligence, conducting national security activities, and providing protective services to the President;
- **To Correctional Institutions and other Law Enforcement Custodians** about inmates;
- **To Government Agencies Administering a Government Program** providing public benefits if the sharing of eligibility or enrollment information among such government agencies or the maintenance of such information in a single or combined data system accessible to all such government agencies is required or expressly authorized by statute or regulation;
- **For Workers' Compensation** compliance purposes or other similar programs that provide benefits for work-related injuries or illness without regard to fault; and

ADDITIONAL NOTICES (continued)

- **To Raise Funds** provided the use or disclosure is to a Business Associate or an institutionally-related foundation and the information used or disclosed is limited to that permitted by HIPAA. You have a right to opt out of receiving fundraising communications. See, the “Your Rights Under HIPAA” section of this Notice.

Required Uses and Disclosures:

We are required to disclose your PHI:

- **To You** upon request;
- **To Your Personal Representative** unless we have a reasonable belief that you may be subjected to domestic violence, abuse, or neglect or treating such person as the personal representative could endanger you, or we decide that it is not in the best interest of the individual to treat the person as your personal representative. We will require written notice/authorization and supporting documentation proving that an individual has been designated as your personal representative; and
- **To the Secretary** of the U.S. Department of Health & Human Services as directed when required to investigate or determine the Plan’s compliance with HIPAA.

Prohibited Uses and Disclosures:

We are prohibited from:

- Using or disclosing **Genetic Information** for underwriting purposes;
- Using or disclosing PHI in violation of a **Restriction** to which KEHP has agreed except where emergency treatment is needed;
- Except as indicated in the Permitted, Limited, and Required Uses and Disclosures sections of this Notice, using or disclosing PHI without a **Valid Authorization** including the use and disclosure of psychotherapy notes, the use and disclosure of information for marketing purposes, and the sale of PHI; and
- Disclosing PHI to a Plan sponsor for the purpose of **Employment-Related Actions or Decisions** or in connection with any other benefit or employee benefit plan of the Plan sponsor.

Uses and Disclosures that Require Authorization:

Except as otherwise described in this Notice, we may not use or disclose PHI without a valid authorization.

A valid authorization is specifically required:

- For any use or disclosure of **Psychotherapy Notes**, except to carry out treatment, payment, or health care operations or to defend KEHP in a legal action or other proceeding brought by you;
- For any use or disclosure of PHI for **Marketing** except if the communication is in the form of a face-to-face communication with you or a promotional gift of nominal value is provided. “Marketing” does not include communications made to describe a health-related product or service that is provided by, or included in the plan of benefits of KEHP; and

ADDITIONAL NOTICES (continued)

- For any disclosure of protected health information which is a **Sale** of such information.

Uses and disclosures of PHI that are not described in this Notice will be made only with the individual's written valid authorization.

A valid authorization must be written in plain language and include specific information. For your convenience, and to ensure that your authorization is valid and contains all required information, you may submit your authorization on KEHP's "Authorization for Release of Your Protected Health Information" form. The form may be obtained by contacting the Privacy Officer or by accessing KEHP's Web site at www.kehp.ky.gov.

You may revoke an authorization previously given at any time provided the revocation is in writing and:

- Except to the extent that KEHP has taken action in reliance on the authorization; or
- If the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Your Rights under HIPAA

You have the right to:

- **Request Restrictions** on certain uses and disclosures of PHI to carry out treatment, payment, or health care operations. You may also request restrictions on uses and disclosures of your PHI to family members, relatives, close personal friends, or other persons identified by you who are involved in your health care or payment for that care. We are not required to agree to your requested restriction except:
 - When the disclosure is for the purpose of carrying out payment or health care operations;
 - The disclosure is not otherwise required by law; and
 - The PHI pertains solely to a health care item or service for which the individual, or person other than the health plan on behalf of the individual, has paid in full.

Your request for a restriction must be made in writing and:

- Identify the information you want to restrict;
- State whether you want to limit our use, disclosure, or both; and
- Identify the persons to whom you want the restriction to apply (i.e. your spouse).

If we agree to a requested restriction on certain uses and disclosures, we will not use or disclose PHI in violation of such restriction, except where the restricted information is needed to provide emergency treatment.

For your convenience, and to ensure that your request contains all necessary information, you may submit your request on KEHP's "Request for Restriction on Use and Disclosure of Your Protected Health Information" form. The form may be obtained by contacting the Privacy Officer or by accessing KEHP's Web site at www.kehp.ky.gov;

ADDITIONAL NOTICES (continued)

- **Receive Confidential Communications.** You may request to receive communications of PHI by alternative means or at alternative locations (i.e. at home, at work). Your request must be made in writing.

We will accommodate all reasonable requests provided:

- You state that the disclosure of all or part of your PHI could endanger you;
- You specify how payment, if any, will be handled; and
- You provide an alternate address or other method of contact.

For your convenience, and to ensure that your request contains all necessary information, you may submit your request on KEHP's "Request for Alternative Communications Regarding Your Protected Health Information" form. The form may be obtained by contacting the Privacy Officer or by accessing KEHP's Web site at www.kehp.ky.gov;

- **Inspect and Copy** your PHI in a designated record set except for:
- Psychotherapy notes;
 - Information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding;
 - PHI that is subject to or exempt from the Clinical Laboratory Improvements Amendments of 1988;
 - PHI not maintained in a designated record set;
 - If access is temporarily suspended because research is in progress, provided you have agreed to the denial of access when consenting to participate in the research;
 - If denial of access under the Privacy Act would meet the requirements of that law; and
 - If your information was obtained from someone other than a health care provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information.

Your request for access to or a copy of your PHI must be made in writing and is subject to a reasonable, cost-based fee.

You have a right to a review of certain denials of access to your PHI by a licensed health care professional who was not directly involved in the denial.

For your convenience, and to ensure that your request contains all necessary information, you may submit your request on KEHP's "Request to Inspect or Copy Your Protected Health Information" form. The form may be obtained by contacting the Privacy Officer or by accessing KEHP's Web site at www.kehp.ky.gov;

- **Amend** your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set. We may deny your request for amendment if we determine that the PHI or record that is the subject of the request:
- Was not created by us, unless you provide a reasonable basis to believe that the originator of the PHI is no longer available to act on the requested amendment;
 - Is not part of the information that you would be permitted to inspect and copy;
 - Would not be available for inspection due to an exception; or
 - Is accurate and complete.

ADDITIONAL NOTICES (continued)

Your request for a restriction must be made in writing and include a reason to support the requested amendment.

You have a right to submit a written statement disagreeing with a denial to amend. If you do not submit a statement of disagreement, you may request that we provide your request for amendment and the denial with any future disclosures of the PHI that is the subject of the amendment.

For your convenience, and to ensure that your request contains all necessary information, you may submit your request on KEHP's "Request to Amend Your Protected Health Information" form. The form may be obtained by contacting the Privacy Officer or by accessing KEHP's Web site at www.kehp.ky.gov;

- **Receive an Accounting of Disclosures** of PHI made by us in the six years prior to the date on which the accounting is requested, except for uses and disclosures:
 - To carry out treatment, payment, and health care operations;
 - Made to you about your PHI;
 - Incident to a use or disclosure otherwise permitted or required by HIPAA;
 - Made pursuant to an authorization;
 - To persons involved in your care or other permitted notifications;
 - For national security or intelligence purposes;
 - To correctional institutions or law enforcement officials; or
 - Temporarily suspended by a health oversight agency or law enforcement official.

Your request for an accounting of disclosures must be made in writing and:

- State in what form you want the list (i.e. paper, electronic);
- State a time period of not longer than six years prior to the date of your request; and
- Is subject to a reasonable, cost-based fee.

For your convenience, and to ensure that your request contains all necessary information, you may submit your request on KEHP's "Request for Accounting of Disclosures of Your Protected Health Information" form. The form may be obtained by contacting the Privacy Officer or by accessing KEHP's Web site at www.kehp.ky.gov;

- **Receive a Paper Copy of this Notice** at any time upon request. Your request must be made in writing and submitted to the Privacy Officer. The Notice may be viewed at our Web site, www.kehp.ky.gov;
- **Be Notified of a Breach of Unsecured Protected Health Information.** Following the discovery of a breach of unsecured PHI we will notify you if your information has been or we reasonably believe your information has been accessed, acquired, used, or disclosed as a result of such breach; and
- **Complain** to us and to the Secretary of the U.S. Department of Health and Human Services ("HHS") if you believe your privacy rights have been violated. Your complaint must:
 - Be in writing;
 - Name the person that is the subject of the complaint;
 - Describe the acts or omissions believed to be in violation of HIPAA; and
 - Be filed within 180 days of when the complainant knew or should have known that the act or omission complained of occurred, unless this time limit is waived by the Secretary of HHS for good cause shown.

You will not be penalized or retaliated against for filing a complaint with us or with the Secretary.

ADDITIONAL NOTICES (continued)

All written requests and complaints must be submitted to:

ATTN: HIPAA Privacy Officer
Commonwealth of Kentucky
Personnel Cabinet
Department of Employee Insurance
502 High Street, 3rd Floor
Frankfort, KY 40601

If you are submitting a complaint to the Secretary of HHS, you should follow the complaint filing instructions on the HHS website at www.hhs.gov.

APPENDIX - A

Dependent eligibility rules and verification requirements are contained in the following chart. Dependent verification for Qualifying Events must be submitted with the Qualifying Event documents. Qualifying Event documents must be signed within the event timeframe.

Definition of Eligible Dependent(s)	Documentation
<p><u>Spouse</u> A person of the opposite sex who is legally married to an employee or retiree.</p>	<p>A legible photocopy of the marriage certificate or a legible photocopy of the top half of the front page of the employee/retiree's most recent federal tax return (Form 1040)</p>
<p><u>Common Law Spouse</u> A person of the opposite sex with whom you have established a Common Law union in a state which recognizes Common Law Marriage (Kentucky does not recognize Common Law Marriage).</p>	<p>A legible photocopy of the certificate of affidavit of common law marriage from a state that does recognize common law marriage.</p>
<p><u>Child Age 0 to 18</u> In the case of a child who has not yet attained his/her 19th birthday, "child" means an individual who is –</p> <ul style="list-style-type: none"> • A son, daughter, stepson, or stepdaughter of the employee/retiree, or • An eligible foster child of the employee/retiree (eligible foster child means an individual who is placed with the employee/retiree by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction), or • An adopted child of the employee/retiree (a legally adopted individual of the employee/retiree, or an individual who is lawfully placed with the employee/retiree for legal adoption by the employee/retiree) or 	<p><u>Natural Child:</u> A legible photocopy of the child's birth certificate showing the name of the employee/retiree as a parent. <u>Step Child:</u> A legible photocopy of the child's birth certificate showing the name of the employee/retiree's Spouse as a parent; and a legible copy of the marriage certificate showing the names of the employee/retiree and the Spouse. <u>Legal Guardian, Adoption, or Foster hild(ren):</u> Legible photocopies of court orders, guardianship documents, affidavits of dependency, with the presiding judge's signature and filed status; or legible adoption or legal placement decrees with the presiding judge's signature.</p>
<p><u>Child Age 19 to 25</u> In the case of a child who has attained his/her 19th birthday but who has not yet attained his/her 26th birthday, "child" means an individual who is –</p> <ul style="list-style-type: none"> • A son, daughter, stepson, stepdaughter, eligible foster child, an adopted child as described above; AND • <u>NOT</u> eligible to enroll in an employer-sponsored health plan offered by the child's full-time employer. 	<p>Must submit the documents described above for children.</p>

APPENDIX - A

<p><u>Disabled Dependent</u></p> <p>A dependent child who is totally and permanently disabled may be covered by KEHP beyond the end of the month in which he/she turns 26, provided the disability (a) started before his/her 26th birthday and (b) is medically-certified by a physician. A dependent child will be considered totally and permanently disabled if, in the judgment of KEHP, the written certification adequately demonstrates that the dependent child is unable to engage in any substantial gainful activity by reason of medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months.</p>	<p>Contact the Enrollment Information Branch at 502-564-1205 for the specific documentation needed.</p>
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Grievance Process for Eligibility and Enrollment Issues

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

Grievances must be filed in writing to:

Personnel Cabinet
Department of Employee Insurance
Attention: Grievance Committee
501 High Street, Second Floor
Frankfort, KY 40601

All grievances must have a completed Grievance Form and be submitted along with a KEHP application. Both can be found on KEHP's website at kehpa.ky.gov.

A grievance must include ALL of the following items:

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

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

A written response will be mailed to you and your agency's Insurance Coordinator stating the decision of the Committee.

The Committee will review a second request **only if** additional relevant facts are provided.

NOTE: This Grievance Committee does not review medical claims. A grievance for a medical claim must be filed with Humana.

Administered by:



Humana

Humana Insurance Company
500 West Main Street
Louisville, KY 40202

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