Humana

SUMMARY PLAN DESCRIPTION

For the

MEDICAL ONLY PLAN

Sponsored by

Kentucky Retirement Systems

Group Numbers: R6575

Plan and Option Numbers: 098/697

Effective: January 1, 2016

GRANDFATHER CLAUSE

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

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

Board of Trustees of the Kentucky Retirement Systems
1260 Louisville Road
Frankfort, KY 40601
Telephone: 1-502-696-8800

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

INTRODUCTION

THE SUMMARY PLAN DESCRIPTION – YOUR HEALTH CARE PLAN GUIDE

Welcome to *your* Kentucky Retirement Systems (KRS)-sponsored health care plan (Plan) administered by Humana Insurance Company (Humana). The Kentucky Retirement Systems (KRS) 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 "Medical 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 telephone number listed on *your* Humana 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 applicable Kentucky law, applicable Kentucky law shall govern.

DEFINED TERMS

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

PRIVACY

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

CONTACT INFORMATION

Customer Service Telephone Number:

Please refer to *your* Humana ID card for the applicable toll-free customer service telephone number.

Website: *You* can access Humana's online services at www.humana.com.

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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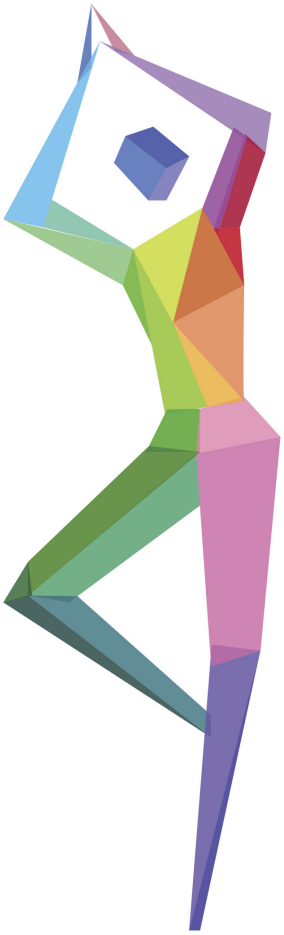
SECTION 1

HEALTH RESOURCES AND PREAUTHORIZATION



HEALTH RESOURCES

Health Resources is a comprehensive set of clinical programs and services available to help *you* better understand *your* health care benefits and how to use them, navigate the health care system when *you* need it, understand treatment options and choices, reduce *your* costs and enhance the quality of *your* 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. All Health Resources programs are subject to change without notice. For additional information or questions regarding any of these programs, please call the toll-free customer service telephone number listed on the back of *your* Humana ID card.

UTILIZATION MANAGEMENT

Utilization Management is administered by Humana consists of *preauthorization*, claims review (*retrospective review*), coordination of care and referral processes that ensure Plan benefits are used properly.. Utilization Management decisions are made using established criteria and care guidelines along with the decisions are made the medical information provided by the patient and the patient's *qualified practitioner*. The patient and his or her *qualified practitioner* 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.

CASE MANAGEMENT

Humana's case management components work to support the *covered person* through the hospitalization or procedure, along with discharge assistance and follow up after discharge to reduce the risk of readmission. Humana performs the following case management services:

- **Acute Case Management:** Acute case managers review cases, perform *concurrent review*, and assist with discharge planning as needed during a *covered person's* hospitalization. Nurses are assigned by facility and may provide either telephonic or onsite case management services.

- **Transitional Case Management:** Transitional case managers will call a *covered person* with a high risk of readmission one to two business days after they leave the *hospital* to make sure they understand their discharge plan of care and that they follow the plan by:
  - Reinforcing the *qualified practitioner's* orders
  - Confirming follow-up appointments
  - Verifying that *prescriptions* were filled
  - Identifying early signs of complications
  - Confirming that discharge services were provided

- **Complex Case Management:** A *covered person* with complex or catastrophic case management needs is referred to a complex case manager for ongoing case management support by telephone after discharge or after their initial post-discharge follow-up conversation. In these situations, complex case managers work closely with the *covered person* and their family until they no longer need this level of support.

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 *you* make a smooth transition to Humana from *your* current health care plan with the least amount of disruption to *your* care.

CONTINUITY OF CARE

If *you* are receiving treatment from a *PAR provider* and that *provider's contract* to provide *medically necessary services* terminates for reasons other than medical competence or professional behavior, *you* may be entitled to continue treatment with that terminating *PAR provider* if at the time of the *PAR provider's* termination *you* are: a) undergoing active treatment for a chronic or acute medical condition; or b) *you* are in the 2nd or 3rd trimester of *your* pregnancy. If this Plan agrees to the continued treatment, *medically necessary services* provided to *you* by the terminating *PAR provider* will continue to be payable at the *PAR provider* benefit level. The maximum duration of continued treatment under this provision may not exceed: a) 90 days from the date of termination of the *provider's contract*; or b) through the delivery of a child, including immediate post-partum care and the follow-up visit within the first six weeks of delivery, in the case of *you* being in the 2nd or 3rd trimester of pregnancy.

HUMANA HEALTH ALERTS

Humana pulls together detailed data for each *covered person*, such as medical and pharmacy claims history, lab results and biometrics and compiles it into a comprehensive clinical profile. This data is continually run through a rules engine, which applies clinical and business rules, and helps identify *covered persons* with potential health issues and route them to the most appropriate support. The rules engine automatically recognizes when a *covered person* is not getting the recommended care, referred to as a "gap in care."

A health alert and a message, if appropriate, are generated to communicate the findings through physician and member messaging. Gaps in care fall in to the following categories:

- Preventive (e.g. cancer screening reminder or notification that a child's immunization was missed)
- Disease-specific (e.g. annual exam reminder to diabetics)
- Care modification (e.g. addressing potentially harmful drug-to-drug or drug-to-disease interactions)

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 1-855-391-8655.

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. The specialized Transplant Department provides effective ways to help *covered persons* and their family members manage the complex and emotional process of organ and tissue transplants. 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.

*MY*HUMANA

Visit Humana's Website at www.humana.comand click on "Sign in or Register" to receive step by step instructions on how to set up *your My*Humana 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 along with estimated costs, if any. *You* can also find *prescription* drug information, information on specific health conditions, financial tools to help with budgeting for health care and more.

*My*Humana Mobile app allows *you* quick access to important information anytime, anywhere. Whether *you* prefer downloading a mobile application, using *your* mobile device or receiving text messages, *you* have the ability to manage *your* healthcare needs virtually.:

Use the MyHumana Mobile app and website to:

- View medical, dental, vision and pharmacy claims;
- View *your* HumanaVitality Dashboard, if applicable;
- Receive medication reminders;
- Research drug prices;
- Locate providers in *your* network;
- Refill *your* Humana Pharmacy *prescriptions*

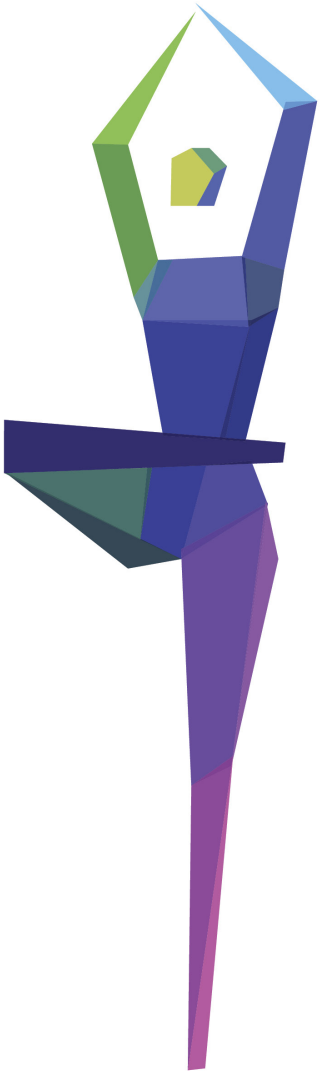
PERSONAL NURSE®

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

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

SECTION 2

MEDICAL BENEFITS



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.

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, *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 "Medical 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.

PRIMARY CARE PHYSICIAN AND SPECIALIST

Primary Care Physician (PCP) is defined as a family practice physician, pediatrician, doctor of internal medicine, general practitioner, nurse practitioner, physician assistant and registered nurse. A specialist would be all other *qualified practitioners*.

CLAIMS PROCESSING EDITS

Payment of *covered expenses* for *services* rendered by a provider is subject to this Plan's claims processing edits. The amount determined to be payable under this Plan's claims processing edits depends on the existence and interaction of several factors. Because the mix of these factors may be different for every claim, the amount paid for a *covered expense* may vary depending on the circumstances. Accordingly, it is not feasible to provide an exhaustive description of the claims processing edits that will be used to determine the amount payable for a *covered expense*, but examples of the most commonly used factors are:

- The intensity and complexity of a *service*;
- Whether a *service* is one of multiple *services* performed at the same *service* session such that the cost of the *service* to the provider is less than if the *service* had been provided in a separate *service* session. For example:
  - Two or more *surgeries* occurring at the same *service* session that do not require two preparation times; or
  - Two or more radiologic imaging views performed on the same body part;
- Whether an assistant surgeon, physician assistant, registered nurse, certified operating room technician or any other health care professional who is billing independently is involved;
- When a charge includes more than one claim line, whether any *service* is part of or incidental to the primary *service* that was provided, or if these *services* cannot be performed together;
- If the *service* is reasonably expected to be provided for the diagnosis reported;
- Whether a *service* was performed specifically for the *covered person*;
- Whether *services* can be billed as a complete set of *services* under one billing code.

This Plan develops claims processing edits based on review of one or more of the following sources, including but not limited to:

- Medicare laws, regulations, manuals and other related guidance;
- Appropriate billing practices;
- National Uniform Billing Committee (NUBC);
- American Medical Association (AMA)/Current Procedural Technology (CPT);
- UB-04 Data Specifications Manual;
- International Classification of Diseases of the U.S. Department of Health and Human Services and the Diagnostic and Statistical Manual of Mental Disorders;
- Medical and surgical specialty certification boards;
- Humana's medical coverage policies; and/or
- Generally accepted standards of medical, *behavioral health* and dental practice based on credible scientific evidence recognized in published peer reviewed medical or dental literature.

Changes to any one of the sources may or may not lead this Plan to modify current or adopt new claims processing edits.

Non-participating providers may bill *covered persons* for any amount this Plan does not pay even if such amount exceeds these claims processing edits. Any amount that exceeds the claims processing edits paid by the *covered person* will not apply to *deductibles*, *out-of-pocket limits* or *PAR provider Plan maximum out-of-pocket limits*, if applicable. The *covered person* will also be responsible for any applicable *deductible*, *coinsurance* amount or *copayment*.

IMPORTANT INFORMATION ABOUT PLAN BENEFITS

Plan benefits and limits (i.e. visit or dollar limits) are applicable per *calendar year*, 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. Plan benefits for covered *services* are applicable after *Medicare* Parts A & B benefits have been applied less *Medicare deductible*. Plan pays for *services* that are *Medicare* covered.

DEDUCTIBLES, COINSURANCE, OUT-OF-POCKET LIMITS, AND LIFETIME MAXIMUM BENEFIT AND OFFICE VISIT COPAYMENTS	
BENEFIT FEATURES	**BENEFIT**
Single Medical *Deductible*	$500 per *covered person*
Medical *Coinsurance*	The Plan pays 100%, *you* pay 0%.
Single Medical *Out-of-Pocket Limit*	$500 per *covered person*
Lifetime Maximum Benefit	Unlimited
Qualified Practitioner Primary Care Physician (PCP) Office Visit *Copayment*	N/A
Qualified Practitioner Specialist Office Visit *Copayment*	N/A
Retail Clinic Copayment	N/A

ROUTINE/PREVENTIVE CHILD CARE SERVICES BIRTH TO AGE 18 (*Services* Received at a Clinic or Outpatient *Hospital*)	
MEDICAL SERVICES	**BENEFIT**
Routine/Preventive Child Care Examination	100% after *deductible*
Routine/Preventive Child Care Vision Screening	100% after *deductible*
Routine/Preventive Child Care Hearing Screening	100% after *deductible*
Routine/Preventive Child Care Laboratory	100% after *deductible*
Routine/Preventive Child Care X-ray	100% after *deductible*
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	100% after *deductible*
Routine/Preventive Child Care Flu/Pneumonia Immunizations	100% after *deductible*

ROUTINE/PREVENTIVE ADULT CARE SERVICES AGE 18 AND OVER (*Services* Received at a Clinic or Outpatient *Hospital*)	
MEDICAL SERVICES	**BENEFIT**
Routine/Preventive Adult Care Examination	100% after *deductible*
Routine/Preventive Adult Care Vision Screening	100% after *deductible*
Routine/Preventive Adult Care Hearing Screening	100% after *deductible*
Routine/Preventive Adult Care Laboratory	100% after *deductible*
Routine/Preventive Adult Care X-ray	100% after *deductible*
Routine/Preventive Adult Care Immunizations (e.g. Shingles Vaccine, Meningitis Vaccine, HPV Vaccine, etc.) Immunizations are covered based on the recommendations by the Department of Health and Human Services - Centers for Disease Control and Prevention	100% after *deductible*
Routine/Preventive Adult Care Flu/Pneumonia Immunizations	100% after *deductible*

ROUTINE/PREVENTIVE ADULT CARE SERVICES AGE18 AND OVER (*Services* Received at a Clinic or Outpatient *Hospital*)	
MEDICAL SERVICES	**BENEFIT**
Routine/Preventive Adult Care Mammograms	100% after *deductible*
Routine/Preventive Adult Care Pap Smears	100% after *deductible*
Routine/Preventive Adult Care Colonoscopy, Proctosigmoidoscopy and Sigmoidoscopy Screenings (including related *services*) (performed at an outpatient facility, *ambulatory surgical center* or clinic location) Colonoscopy, Proctosigmoidoscopy and Sigmoidoscopy Screenings are payable under this Routine/Preventive Adult Care Benefit when billed by the *qualified practitioner* with a routine diagnosis.	100% after *deductible*
Routine/Preventive Adult Care Prostate Specific Antigen (PSA) Testing	100% after *deductible*
Breast Feeding Counseling	100% after *deductible*
Breast Feeding Support and Supplies	100% after *deductible*

ROUTINE/PREVENTIVE ADULT CARE SERVICES AGE18 AND OVER (*Services* Received at a Clinic or Outpatient *Hospital*)

MEDICAL SERVICES	BENEFIT
Contraceptive Methods - devices (e.g. IUD or diaphragms), injections, implant insertion/removal, emergency contraceptives and condoms; Sterilization - tubal ligation and vasectomy (excludes birth control pills/patches and spermicide) For information on *prescription* drug coverage for birth control pills/patches, spermicide, emergency contraceptives and condoms, please see *your prescription* drug benefits.	100% after *deductible* If *services* are not to prevent pregnancy, then they are payable the same as any other *sickness*.

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

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

ROUTINE VISION SERVICES

MEDICAL SERVICES	BENEFIT
Routine Vision Examination	Not covered
Routine Vision Refraction	Not covered

ROUTINE VISION SERVICES	
MEDICAL SERVICES	**BENEFIT**
Eyeglass Frames and Lenses and Contact Lenses	Not covered
Eyeglass Frames and Lenses and Contact Lenses Limits	Not covered

ROUTINE HEARING SERVICES	
MEDICAL SERVICES	**BENEFIT**
Routine Hearing Examination	Not covered
Routine Hearing Testing	Not covered
Hearing Aids and Fitting	Not covered

QUALIFIED PRACTITIONER SERVICES (Non-Routine/Non-Preventive Care *Services*)	
MEDICAL SERVICES	**BENEFIT**
Diagnostic Office Examination at a Clinic, including Second Surgical Opinion – *Qualified Practitioner* Primary Care Physician	100% after *deductible*

QUALIFIED PRACTITIONER SERVICES (Non-Routine/Non-Preventive Care *Services*)	
MEDICAL SERVICES	**BENEFIT**
Diagnostic Office Examination at a Clinic, including Second Surgical Opinion - *Qualified Practitioner* Specialist	100% after *deductible*
Office Examination at *Retail Clinic* including Second Surgical Opinion	100% after *deductible*
If an office examination is billed from an outpatient location, the *services* will be payable the same as an office examination at a clinic.	
Diagnostic Laboratory at a Clinic	100% after *deductible*
Diagnostic X-ray at a Clinic (other than *advanced imaging*)	100% after *deductible*
Independent Laboratory	100% after *deductible*
Advanced Imaging at a Clinic	100% after *deductible*
Allergy Testing at a Clinic	100% after *deductible*
Allergy Serum/Vials at a Clinic	100% after *deductible*
Allergy Injections at a Clinic	100% after *deductible*

QUALIFIED PRACTITIONER SERVICES (Non-Routine/Non-Preventive Care *Services*)	
MEDICAL SERVICES	**BENEFIT**
Injections at a Clinic (other than routine immunizations, flu or pneumonia immunizations, contraceptive injections for birth control reasons and allergy injections)	100% after *deductible*
Anesthesia at a Clinic	100% after *deductible*
Surgery at a Clinic (including *Qualified Practitioner*, Assistant Surgeon and Physician Assistant)	100% after *deductible*
Medical and Surgical Supplies	100% after *deductible*
Eyeglasses or Contact Lenses after Cataract *Surgery* (initial pair only)	100% after *deductible*
Diabetic Nutritional Counseling (*Diabetes Self-Management Training*) (all places of *service*)	100% after *deductible*
Diabetes Supplies	Payable the same as medical supplies.

DENTAL/ORAL SURGERIES COVERED UNDER THE MEDICAL PLAN	
MEDICAL SERVICES	**BENEFIT**
Dental/Oral *Surgeries*	Payable the same as any other *sickness*.
Please refer to the "Medical Covered Expenses" section, Dental/Oral Surgeries Covered Under the Medical Plan, for a list of oral surgeries covered under this benefit.	

REVERSAL OF STERILIZATION AND ABORTIONS	
MEDICAL SERVICES	**BENEFIT**
Reversal of Sterilization	Not Covered
Life Threatening Abortions	Payable the same as any other *sickness*
Elective Abortions	Not Covered

MATERNITY (Normal, C-Section and Complications)	
MEDICAL SERVICES	**BENEFIT**
Inpatient *Hospital* Room and Board and Ancillary Facility *Services*	Payable the same as any other *sickness*.

MATERNITY (Normal, C-Section and Complications)	
MEDICAL SERVICES	**BENEFIT**
Birthing Center Room and Board and Ancillary *Services*	Payable the same as any other *sickness*.
Qualified Practitioner Services	Payable the same as any other *sickness*.
Dependent Daughter Maternity	Payable the same as any other *sickness* for normal maternity only.
Newborn Inpatient *Qualified Practitioner Services*	100% after *deductible.*
Newborn Inpatient Facility *Services*	100% The newborn *deductible* and *copayment* will be waived for facility *services*.

INPATIENT SERVICES	
MEDICAL SERVICES	**BENEFIT**
Inpatient *Hospital* Room and Board and Ancillary Facility *Services*	100% for days 1-150 Hospital Care Beyond 150 Days During A Benefit Period - 80% Subject To The Payment Of The Semi-Private Room Rate. Maximum Of 365 Additional Days Per Lifetime
Qualified Practitioner Inpatient *Hospital* Visit	100% after *deductible*

INPATIENT SERVICES	
MEDICAL SERVICES	**BENEFIT**
Qualified Practitioner Inpatient *Surgery* and Anesthesia	100% after *deductible*
Qualified Practitioner Inpatient Pathology and Radiology	100% after *deductible*
Private Duty Nursing	80% up to a maximum of $2,500 per year

SKILLED NURSING SERVICES	
MEDICAL SERVICES	**BENEFIT**
Skilled Nursing Room and Board and Ancillary Facility *Services*	100% after *deductible* days 1 -100, then 80% days 101-365 (after 3 day *hospital* stay. "This plan pays 100% of member's Medicare Part A coinsurance for the 21st to 100th day."
Skilled Nursing *Qualified Practitioner* Visit	100% after *deductible*

OUTPATIENT AND AMBULATORY SURGICAL CENTER SERVICES	
MEDICAL SERVICES	**BENEFIT**
Ambulatory Surgical Center Facility *Services*	100% after *deductible*
Ambulatory Surgical Center Ancillary *Services*	100% after *deductible*
Outpatient *Hospital* Facility Surgical *Services*	100% after *deductible*
Outpatient *Hospital* Facility Non-Surgical *Services* (e.g. clinic facility *services*; observation)	100% after *deductible*
Outpatient *Hospital* Surgical and Non-Surgical Ancillary *Services* (e.g. supplies; medication; anesthesia)	100% after *deductible*
Outpatient *Hospital* Facility Diagnostic Laboratory and X-ray (other than *advanced imaging*)	100% after *deductible*
Outpatient *Hospital* Facility *Advanced Imaging*	100% after *deductible*
Outpatient *Hospital* and *Ambulatory Surgical Center Qualified Practitioner* Visit	100% after *deductible*

OUTPATIENT AND AMBULATORY SURGICAL CENTER SERVICES	
MEDICAL SERVICES	**BENEFIT**
Outpatient *Hospital* and *Ambulatory Surgical Center Surgery* (including surgeon; assistant surgeon; and physician assistant) and Anesthesia	100% after *deductible*
Outpatient *Hospital* and *Ambulatory Surgical Center* Pathology and Radiology	100% after *deductible*

EMERGENCY AND URGENT CARE SERVICES	
MEDICAL SERVICES	**BENEFIT**
Emergency Room Facility and Ancillary *Services* (true *emergency*)	100% after *deductible*
Foreign Travel Emergency Room Facility and Ancillary Services (true-emergency)	80% after *deductible* limited to a $5,000 annual benefit.
Foreign Travel Emergency and Ancillary Services (true-emergency) Limitations	Limited to a $5,000 annual benefit.

EMERGENCY AND URGENT CARE SERVICES	
MEDICAL SERVICES	**BENEFIT**
Emergency Room All Physician *Services* (including Emergency Room Physician, Radiologist, Pathologist, Anesthesiologist and ancillary *services* billed by an Emergency Room Physician) (true *emergency*)	100% after *deductible*
Emergency Room Facility and Ancillary *Services* (non-emergency)	100% after *deductible*
Emergency Room All Physician *Services* (including Emergency Room Physician, Radiologist, Pathologist, Anesthesiologist and ancillary *services* billed by an Emergency Room Physician) (non-emergency)	100% after *deductible*
Urgent Care Center (facility, ancillary *services* and *qualified practitioner services*)	100% after *deductible*

HOSPICE SERVICES	
MEDICAL SERVICES	**BENEFIT**
Hospice Inpatient Room and Board and Ancillary *Services*	100% after *deductible*
Hospice Outpatient (including hospice home visits)	100% after *deductible*
Hospice *Qualified Practitioner* Visit	100% after *deductible*

HOME HEALTH CARE SERVICES	
MEDICAL SERVICES	**BENEFIT**
Home Health Care *Services*	100% after *deductible*
Home therapy benefits will be reimbursed under the home health care benefit. If therapies are done in the home (such as physical or occupational therapy), these therapy *services* will apply to the home health care limits If therapies and home health visits are done on the same day the *services* will track as one visit per day.	
Home Health Care Ancillary *Services* (excluding *durable medical equipment*, prosthetics and private duty nursing)	100% after *deductible*

DURABLE MEDICAL EQUIPMENT (DME)	
MEDICAL SERVICES	**BENEFIT**
Durable Medical Equipment (DME)	100% after *deductible*
Prosthesis	100% after *deductible*
Wigs for cancer patients with hair loss resulting from chemotherapy and/or radiation therapy	Not covered

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

AMBULANCE SERVICES	
MEDICAL SERVICES	**BENEFIT**
Ground *Ambulance*	100% after *deductible*
Air *Ambulance*	100% after *deductible*

MORBID OBESITY SERVICES	
MEDICAL SERVICES	**BENEFIT**
Morbid Obesity	Not covered

MEDICAL SERVICES	**BENEFIT**
Obesity	Not covered

TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ)	
MEDICAL SERVICES	**BENEFIT**
Temporomandibular Joint Dysfunction (TMJ) (Other than Splint/Appliances)	Not covered
Temporomandibular Joint Dysfunction (TMJ) Splint/Appliances	Not covered

DENTAL INJURY SERVICES	
MEDICAL SERVICES	**BENEFIT**
Dental Injuries	Payable the same as any other *sickness*.
Please see the "Medical Covered Expenses" section, Dental Injury, for benefit details.	

INFERTILITY SERVICES	
MEDICAL SERVICES	**BENEFIT**
Infertility Counseling and Treatment	Not covered
Artificial Means of Achieving Pregnancy	Not Covered
Sexual Dysfunction/Impotence	Not Covered

THERAPY SERVICES	
MEDICAL SERVICES	**BENEFIT**
Chiropractic Examinations	100% after *deductible*
Chiropractic Laboratory and X-ray	100% after *deductible*

THERAPY SERVICES	
MEDICAL SERVICES	**BENEFIT**
Chiropractic Manipulations	100% after *deductible*
Chiropractic Therapy	100% after *deductible*
Chiropractic Limits	Limitations vary according to Medicare guidelines
Physical Therapy (Clinic and Outpatient)	100% after *deductible*
Occupational Therapy (Clinic and Outpatient)	100% after *deductible*
Speech Therapy (Clinic and Outpatient)	100% after *deductible*
Cognitive Therapy (Clinic and Outpatient)	100% after *deductible*
Therapy Limits	Limitations vary according to Medicare guidelines
Acupuncture	Not Covered
Respiratory Therapy and Pulmonary Therapy (Clinic and Outpatient)	100% after *deductible*
Vision Therapy (eye exercises to strengthen the muscles of the eye) (Clinic and Outpatient)	Not covered

THERAPY SERVICES	
MEDICAL SERVICES	**BENEFIT**
Chemotherapy (Clinic and Outpatient)	100% after *deductible*
Radiation Therapy (Clinic and Outpatient)	100% after *deductible*
Cardiac Rehabilitation (Phase II) Phase I is covered under the inpatient facility benefits. Phase III, an unsupervised exercise program, is not covered.	100% after *deductible*

TRANSPLANT SERVICES	
Medicare approved Transplants will be covered	
MEDICAL SERVICES	**HUMANA NATIONAL TRANSPLANT NETWORK (NTN) FACILITY**
Organ Transplant Medical *Services*	Payable the same as any other *sickness*.
Organ Transplant Medical *Services* Limits	None
Non-Medical *Services* - Lodging and Transportation	Not covered
Covered expenses for organ transplants performed at a Humana National Transplant Network facility will aggregate toward the Plan *out-of-pocket limits*. *Covered expenses* for organ transplants performed at a facility other than a Humana National Transplant Network facility do not aggregate toward the Plan *out-of-pocket limits*.	

BEHAVIORAL HEALTH INPATIENT SERVICES	
MEDICAL SERVICES	**BENEFIT**
Inpatient *Behavioral Health* Room and Board and Ancillary *Services*	100%
Inpatient *Behavioral Health* Professional *Services*	100%
Behavioral Health Partial Hospitalization Services	100% after *deductible*

BEHAVIORAL HEALTH INPATIENT SERVICES	
MEDICAL SERVICES	**BENEFIT**
Behavioral Health Residential Treatment Facility Services	Not covered
Behavioral Health Half-way House *Services*	Not covered

BEHAVIORAL HEALTH CLINIC, OUTPATIENT AND INTENSIVE OUTPATIENT SERVICES	
MEDICAL SERVICES	**BENEFIT**
Behavioral Health Therapy and Office Visit *Services* (Clinic, Outpatient and *Intensive Outpatient*)	100% after *deductible*
Diagnostic Examination (Clinic)	Payable the same as any other *sickness*.
Laboratory and X-ray (Clinic and Outpatient)	Payable the same as any other *sickness*.

OTHER COVERED EXPENSES	
MEDICAL SERVICES	**BENEFIT**
Other Covered Expenses	Payable the same as any other *sickness*.

HOW BENEFITS PAY

This Plan may require *you* to satisfy *deductible(s)* before this Plan begins to share the cost of most medical *services*. If 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 Medical Schedule of Benefits.

DEDUCTIBLE

A *deductible* is a specified dollar amount that must be satisfied per *covered person* per *calendar year* before this Plan pays benefits for certain specified *services*. Only charges which qualify as a *covered expense* may be used to satisfy the *deductible*. *Copayments* do not apply toward the *deductible*.
The single *deductible* applies to each *covered person* each *calendar year*.

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 Medical Schedule of Benefits after the *deductible*, if any, is satisfied each *calendar year*, subject to any *calendar year* maximums.

OUT-OF-POCKET LIMIT

An *out-of-pocket limit* is a specified dollar amount that must be satisfied per *covered person* per *calendar year* before a benefit percentage will be increased. The *out-of-pocket limits* are stated on the Medical Schedule of Benefits.

Once a *covered person* satisfies the single *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.

ROUTINE/PREVENTIVE SERVICES

Covered expenses are payable as shown on the Medical 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 toll-free customer service telephone number listed on *your* Humana ID 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.

QUALIFIED PRACTITIONER SERVICES

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

Second Surgical Opinion

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

Multiple Surgical Procedures

If multiple or bilateral surgical procedures are performed at one operative session, the amount payable for these procedures will be limited to the *maximum allowable fee* for the primary surgical procedure. When a *participating provider* is utilized, subsequent procedures will be paid in accordance with the *provider contract*. When a *non-participating provider* is utilized, the amount payable will be: 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 10% 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 Medical Schedule of Benefits and include the following procedures:

1. Excision of partially or completely unerupted impacted teeth;
2. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological examination;
3. Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
4. Reduction of fractures and dislocations of the jaw;
5. External incision and drainage of cellulitis;
6. Incision of accessory sinuses, salivary glands or ducts;
7. Frenectomy (the cutting of the tissue in the midline of the tongue);
8. Dental osteotomies.

REVERSAL OF STERILIZATION AND ABORTIONS

Family planning *services* are payable as shown on the Medical 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 Medical 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.

Please refer to the "Eligibility and Effective Date of Coverage" section regarding newborn eligibility and enrollment.

Birthing Centers

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

INPATIENT HOSPITAL

Inpatient *hospital services* are payable as shown on the Medical 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*. 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.

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 Medical 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. Occurs while *you* or an eligible *dependent* are covered under this Plan;

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

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

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

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

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

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

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

4. A daily record for each patient;

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

6. A utilization review plan.

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

OUTPATIENT AND AMBULATORY SURGICAL CENTER

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

EMERGENCY AND URGENT CARE SERVICES

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

HOSPICE SERVICES

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

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

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

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

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

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

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

5. Nutritional counseling;

6. Physical or occupational therapy;

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

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

Hospice care benefits do NOT include:

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

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

3. Funeral arrangements;

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

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

6. Housecleaning and household maintenance;

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

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

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

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

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

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

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

HOME HEALTH CARE

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

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

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

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

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

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

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

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

The home health care plan consists of:

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

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

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

Home health care benefits do not include:

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

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

3. Charges for supervision of home health care providers;

4. Private duty nursing;

5. *Durable medical equipment* and prosthetics.

DURABLE MEDICAL EQUIPMENT (DME)

Durable medical equipment (DME) is payable as shown on the Medical Schedule of Benefits and includes *DME* provided within a *covered person's* home. Rental is allowed up to, but not to exceed, the total 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*

1. The manufacturer's warranty is expired; and

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

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

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

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

1. The manufacturer's warranty is expired; and

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

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

4. Replacement is required due to a change in condition that makes the current equipment non-functional.

Duplicate *DME* is not covered.

Prosthetics

Initial prosthetic devices or supplies, including but not limited to, limbs and eyes are payable as shown on the Medical 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 Medical Schedule of Benefits. For more information regarding the specific *specialty drugs* covered under this Plan, please call the toll-free customer service telephone number listed on *your* Humana ID card or visit Humana's website at www.humana.com:

AMBULANCE

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

DENTAL INJURY

Dental injury services are payable as shown on the Medical 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.

Services must begin within 90 days after the date of the *dental injury*. *Services* must 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 Medical Schedule of Benefits.

Chiropractic Care

Chiropractic care for the treatment of a *bodily injury* or *sickness* is payable as shown on the Medical Schedule of Benefits.

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 toll-free customer service telephone number listed on *your* Humana ID card when in need of these *services*.

Covered Organ Transplant

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

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

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

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

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

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

Exclusions

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

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

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

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

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

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

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

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

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

Covered Services

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

1. *Hospital* and *qualified practitioner services*, payable as shown on the Medical 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;*

BEHAVIORAL HEALTH SERVICES

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

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.

OTHER COVERED EXPENSES

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

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

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

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

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

5. Routine costs associated with clinical trials, when approved by this Plan. For additional details, go to www.humana.com or call the toll-free customer service telephone number listed on *your* Humana ID card.

6. Cranial banding, when approved by this Plan. For additional details, go to www.humana.com or call the toll-free customer service telephone number listed on *your* Humana ID card

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 *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.

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* or devices, 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;

6. Hair prosthesis, hair transplants or hair implants;

7. Dental *services* or appliances for the treatment of the teeth, gums, jaws or alveolar processes, including but not limited to, implants and related procedures, routine dental extractions and orthodontic procedures, unless specifically provided under this Plan;

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. Marriage counseling;

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, air purifiers, water purifiers, vacuum cleaners, waterbeds, hypoallergenic mattresses or pillows or exercise equipment;
    b. Motorized transportation equipment (e.g. scooters), escalators, elevators, ramps or modifications or additions to living/working quarters or transportation vehicles;
    c. Personal hygiene equipment including bath/shower chairs and transfer equipment or supplies;
    d. Personal comfort items including cervical pillows, gravity lumbar reduction chairs, swimming pools, whirlpools, spas or saunas;
    e. Medical equipment including blood pressure monitoring devices, PUVA lights and stethoscopes;
    f. Communication system, telephone, television or computer systems and related equipment or similar items or equipment;
    g. Communication devices, except after surgical removal of the larynx or a diagnosis of permanent lack of function of the larynx.

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

15. *Services* that are <u>not</u> *medically necessary*, except routine/preventive *services*;

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

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

18. 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;

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

20. 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.

21. 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.

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

23. With the exception of counseling for smoking cessation or unless otherwise approved by Medicare, treatment of nicotine habit or addiction, including, but not limited to hypnosis, smoking cessation products, classes or tapes, unless otherwise determined by this Plan;

24. Vitamins, dietary supplements and dietary formulas, except enteral formulas, nutritional supplements or low protein modified food products for the treatment of an inherited metabolic disease, e.g. phenylketonuria (PKU);

25. *Prescription* drugs and *self-administered injectable drugs*, unless administered to *you*:
    a. While inpatient in a *hospital*, *qualified treatment facility* or skilled nursing facility; or
    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.

26. 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.

27. *Off-evidence drug indications*;

28. Over-the-counter, non-prescription medications, unless for drugs, medicines or medications on the Women's Healthcare Drug List with a *prescription* from a *qualified practitioner.* See the Prescription Drug Benefit;

29. 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*);

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

31. 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.

32. 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*.

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

34. 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;

35. *Alternative medicine*;

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

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

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

39. *Custodial care* and *maintenance care* outside of the Private Duty Nursing Benefit

40. 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;

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

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

43. *Ambulance services* for routine transportation to, from or between medical facilities and/or a *qualified practitioner's* office;

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

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

46. Communications or travel time;

47. 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. Hyperhidrosis *surgery*;
    j. Lactation therapy; or
    k. Sensory integration therapy.

48. 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;

49. Routine physical examinations and related *services* for occupation, employment, school, sports, camp, travel, purchase of insurance or premarital tests or examinations, unless specifically provided under this Plan;

50. Surrogate parenting;

51. Any *bodily injury* or *sickness* arising from or sustained in the course of any occupation or employment for compensation, profit or gain for which:
    a. Benefits are provided or payable under any Workers' Compensation or Occupational Disease Act or Law, or
    b. Coverage was available under any Workers' Compensation or Occupational Disease Act or Law regardless of whether such coverage was actually purchased, unless covered by Medicare:

52. Routine vision examinations;

53. Routine vision refraction;

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

55. Vision therapy;

56. Routine hearing examinations;

57. Routine hearing testing;

58. 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;

59. 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.

60. *Services* for a reversal of sterilization;

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

62. Wigs;

63. Obesity *services*;

64. *Morbid obesity services*;

65. Surgical procedures for the removal of excess skin and/or fat in conjunction with or resulting from weight loss or weight loss *surgery*;

66. *Services* for any jaw joint problem including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder or other conditions of the joint linking the jaw bone and skull and treatment of the facial muscles used in expression and mastication functions, for symptoms including but not limited to, headaches;

67. Infertility counseling and treatment *services*;

68. 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;

69. Acupuncture;

70. *Residential treatment facilities*;

71. Halfway-house *services*.

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

COORDINATION OF BENEFITS

BENEFITS SUBJECT TO THIS PROVISION

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

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

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

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

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

EFFECT ON BENEFITS

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

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 will be followed to determine which plan is primary.

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

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

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

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

COORDINATION OF BENEFITS WITH MEDICARE

If you are a retiree covered by Medicare due to age or disability, *Medicare* is your primary coverage and this Plan is considered secondary coverage for you and any Eligible Dependents entitled to receive *Medicare*.

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.

For the purposes of determining benefits payable for any *covered person* who is eligible to enroll for *Medicare* Part B, but does not, Humana assumes the amount payable under *Medicare* Part B to be the amount the *covered person* would have received if he or she enrolled for it. A *covered person* is considered to be eligible for *Medicare* on the earliest date coverage under *Medicare* could become effective for him or her.

CALCULATION AND PAYMENT OF BENEFITS

Medicare benefits are payable before any benefits are payable by this Plan. To receive benefits from the Plan when *Medicare* is the primary coverage, you must first meet any applicable Deductible under the Plan. After you satisfy the applicable Deductible, the Plan begins to pay benefits for covered expenses. The benefits of this Plan will be reduced by the full amount of all *Medicare* benefits the *covered person* is entitled to receive, whether or not they were actually enrolled for *Medicare*

RIGHT OF RECOVERY

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

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

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

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

SUBMITTING A CLAIM

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

- A claim must be filed with Humana in writing and delivered to Humana by mail, postage prepaid. However, a submission to obtain preauthorization 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* Humana ID 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 claim was incurred for *Non-PAR provider* claims, except if *you* were legally incapacitated. Claims should be submitted by a *PAR provider* in accordance with the timely filing period outlined in that *provider's contract* with Humana (typically 180 days for physicians and 90 days for facilities and ancillary providers, however, a provider's contractual timely filing period may vary). 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.

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

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 *participating 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 *covered member,*" and send it directly to Humana. *You* will receive a written explanation of an *adverse benefit determination*. Humana reserves the right to request any information required to determine benefits or process a claim. *You* or the provider of *services* will be contacted if additional information is needed to process *your* claim.

When an *covered member'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, including a statement of the *claimant's* right to bring a civil action

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 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). This Plan uses a one level *appeal* process for all *adverse benefit determinations*. Humana will make the final determination on the *appeal*.

An *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

However, a *claimant* on *appeal* may request an expedited *appeal* of an adverse *urgent care claim* decision, orally or in writing. In such case, all necessary information, including this Plan's benefit determination on review, will be transmitted between this Plan and the *claimant* by telephone, facsimile, or other available similarly expeditious method, to the extent permitted by applicable law.

Appeals of denied claims will be conducted promptly, will not defer to the initial determination, and will not be made by the person that 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 free of charge, and may submit issues and comments in writing. In addition, 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 was based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is *experimental, investigational or 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 PERIOD FOR DECISIONS ON APPEAL

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

Urgent Care Claims	As soon as possible, but not later than 72 hours after Humana has received the *appeal* request. If oral notification is given, written notification will follow in hard copy or electronic format within the next three days.
Pre-Service Claims	Within a reasonable period, but not later than 30 days after Humana has received the *appeal* request.
Post-Service Claims	Within a reasonable period, but not later than 60 days after Humana has received the *appeal* request.
Concurrent Care Decisions	Within the time periods specified above, depending on the type of claim involved.

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 state 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 on *appeal*. 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 allow.

EXHAUSTION

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

STANDARD EXTERNAL REVIEW

Request for an External Review

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

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

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

Preliminary Review

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

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

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

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

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

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

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

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

Referral to an Independent Review Organization (IRO)

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

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

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

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

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

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

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

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

f. A statement that judicial review may be available to the *claimant*; and
g. Current contact information, including telephone 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

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

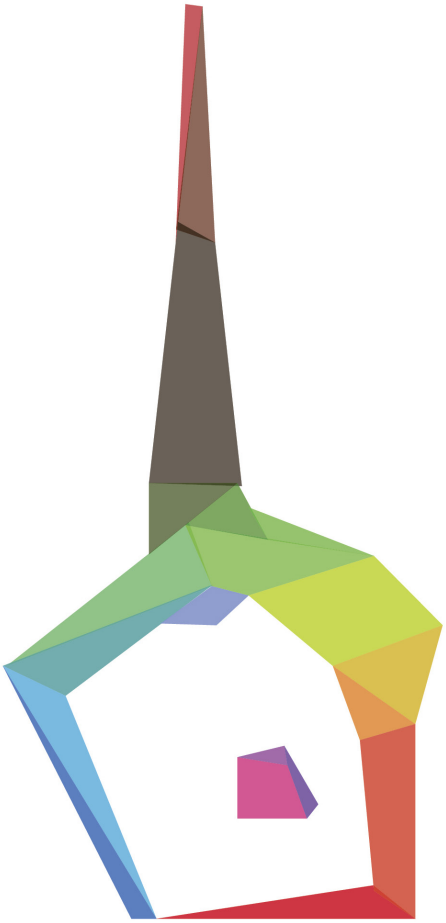
The *IRO* must provide notice of the *final external review decision* as expeditiously as the *claimant's* medical condition or circumstances require, but no more than 72 hours after the *IRO* receives the request for an expedited *external review*, following the notice requirements outlined in the "Standard 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 ON INTERNAL CLAIMS AND APPEALS AND EXTERNAL REVIEW RIGHTS

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.

SECTION 3

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE



ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

You are eligible for coverage under the Kentucky Retirement Systems Health Plan ("the Plan") if you are the recipient of a monthly retirement allowance from Kentucky Retirement Systems either:

- Under its formal retirement program, and you are eligible for Medicare, or
- Due to a disability, and you are eligible for Medicare as a result of that disability.

You also can enroll your eligible *dependents* in this Plan. They too must be Medicare-eligible.

Enrolling For Coverage

If you would like medical coverage under this plan, you must apply for it within 30 calendar days following the first of the month that your first retirement allowance is issued. If you do not apply for coverage within that time frame, you will have to wait for the annual open enrollment period or for a qualified status change. You can enroll for coverage or change your current Plan coverage during annual open enrollment. You also can enroll in the Plan if you become newly eligible during the year or if you experience a qualified status change.

When Coverage Begins

If you make a coverage election during the annual open enrollment, your coverage becomes effective on the next January 1. If you make a new coverage election during the year, your coverage becomes effective on the first day of the month following the month in which the retirement office receives your enrollment form. The effective date of the coverage can be no earlier than your Medicare eligibility date.

When You Can Make Changes

You may change your Plan coverage during the year if you have a qualified status change. If you want to change your election as a result of a status change, your new election must be made within 30 days from the date of the status change. Status changes include:

- Marriage, divorce, legal separation or annulment.
- Birth or adoption (or placement for adoption) of a child.
- Death of a covered spouse or child.
- Loss or gain of eligibility for insurance coverage for you or a covered *dependent*. This does not include a voluntary termination of coverage. This includes non-payment of premiums.
- Change in employment status including termination or commencement of employment, a commencement of or a return from an unpaid leave of absence, or a change in work schedule (including part-time to full-time or vice versa) for you, your spouse or your *dependent*.
- Change in health insurance eligibility due to a relocation of residence or work place for you, your spouse or your *dependent*. Applies to members returning home from out of country or leaving jail.
- A judgment, decree or order resulting from your marriage, divorce, legal separation, annulment or change in child custody requiring you to add or allowing you to drop coverage for your *dependents*.
- Your or your spouse's or *dependent* child's entitlement to Medicare benefits. If you and/or your *dependents* did not enroll in Medicare Part B, at the time you became eligible, subsequent enrollment in Part B is not a qualifying event allowing you to enroll in the Plan outside of the Open Enrollment period.

- A significant increase in cost, or reduction in benefits, of coverage under the Plan or your spouse's plan.
- A change in a spouse's or *dependent* child's coverage under another plan that would permit a new election under that plan and applicable IRS regulations.
- Your or your *dependent's* prior coverage was COBRA continuation that has since been exhausted. You have 30 days from the date of the status change to revise your elections. Please keep in mind that the change you request must be consistent with your status change. For instance, if you adopt a child, you may enroll your new *dependent* for medical coverage, but you cannot change medical plan options. Generally, your change in coverage will become effective on the first day of the month following the month in which the retirement office receives your enrollment form.

TERMINATION OF COVERAGE

When Coverage Ends

Your coverage under this plan will end on the earliest of the following dates:

- December 31 following the open enrollment in which you terminate coverage.
- The effective date of an applicable status change.
- The last day of the month in which KRS receives your completed Form 6211 (this form can be found on page D-51).
- The date of death for the Covered Person.
- The end of the month in which eligibility is lost due to a qualified status change

Loss of Benefits

You or your *dependents* also may experience a reduction in or loss of benefits in any of the following circumstances:

- *You* fail to follow the Plan's procedures.
- The last day of the month in which full payment of premiums was received if *you* stop making contributions for coverage.
- *You* fail to reimburse the Plan for a claim that was paid in error or otherwise, but was later denied.
- *You* receive reimbursement for a Covered Expense by another medical plan that is primary to the Plan while also receiving primary reimbursement from the Plan.
- *You* receive a judgment, settlement, or otherwise from any person or entity with respect to the sickness, injury or other condition that gives rise to the expenses the Plan pays.
- *You* are found to have committed a fraudulent act against the Plan including, but not limited to, the fraudulent filing of a claim for reimbursement.
- The plan is amended or terminated, but only with respect to expenses incurred after the amendment or termination becomes effective.

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* has established and continues to maintain this Plan for the benefit of its *retirees* 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*. 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*, 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.

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 a person 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 person* to the benefits payment.

CONSTRUCTION OF PLAN TERMS

The *Plan Manager* 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* shall be final and uncontestable.

REIMBURSEMENT/SUBROGATION

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

1. This Plan shall be repaid the full amount of the *covered expenses* it pays from any amount received from others for the *bodily injuries* or losses which necessitated such *covered expenses*. 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.

2. This Plan's right to repayment is, and shall be, prior and superior to the right of any other person or entity, including the *beneficiary*.

3. The right to recover amounts from others for the injuries or losses which necessitate *covered expenses* is jointly owned by this Plan and the *beneficiary*. This Plan is subrogated to the *beneficiary's* rights to that extent. Regardless of who pursues those rights, the funds recovered shall be used to reimburse this Plan as prescribed above; this Plan has no obligation to pursue the rights for an amount greater than the amount that it has paid, or may pay in the future. The rights to which this Plan is subrogated are, and shall be, prior and superior to the rights of any other person or entity, including the *beneficiary*.

4. The *beneficiary* will cooperate with this Plan in any effort to recover from others for the *bodily injuries* and losses which necessitate *covered expense* payments by this Plan. The *beneficiary* will notify this Plan immediately of any claim asserted and any settlement entered into, and will do nothing at any time to prejudice the rights and interests of this Plan. Neither this Plan nor the *beneficiary* shall be entitled to costs or attorney fees from the other for the prosecution of the claim.

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 this 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.

DUTY TO COOPERATE IN GOOD FAITH

You are obliged to cooperate with Humana in order to protect this Plan's recovery rights. Cooperation includes promptly notifying Humana that *you* may have a claim, providing Humana relevant information, and signing and delivering such documents as Humana reasonably request to secure this Plan's recovery rights. *You* agree to obtain this Plan's consent before releasing any party from liability for payment of medical expenses. *You* agree to provide Humana with a copy of any summons, complaint or any other process serviced in any lawsuit in which *you* seek to recover compensation for *your bodily injury* or *sickness* and its treatment.

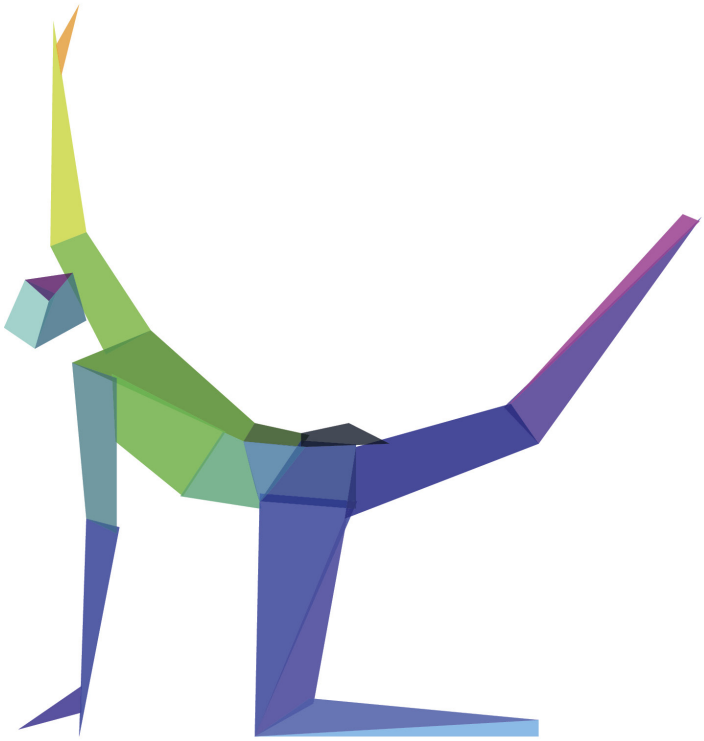
You will do whatever is necessary to enable Humana to enforce this Plan's recovery rights and will do nothing after loss to prejudice this Plan's recovery rights.

You agree that *you* will not attempt to avoid this Plan's recovery rights by designating all (or any disproportionate part) of any recovery as exclusively for pain and suffering.

Failure of the *covered person* to provide Humana such notice or cooperation, or any action by the *covered person* resulting in prejudice to this Plan's rights will be a material breach of this Plan and will result in the *covered person* being personally responsible to make repayment. In such an event, this Plan may deduct from any pending or subsequent claim made under this Plan any amounts the *covered person* owes this Plan until such time as cooperation is provided and the prejudice ceases.

SECTION 5

NOTICES



PRIVACY OF PROTECTED HEALTH INFORMATION

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It applies to the benefits in the Kentucky Retirement Systems Health Plans that pay for the cost of, or provide, health and/or prescription drug benefits. We will refer to these benefits in this Notice as "the Plan." If you receive health benefits through a third party administrator (such as Humana) that provides benefits administration services through and to the Plan, you may also receive a notice from the third party administrator. That notice will describe how the insurer will use your health information and provide your rights.

This Notice also describes your rights to access and control your protected health information, as well as certain obligations we have regarding the use and disclosure of your protected health information. "Protected health information" ("PHI") is medical information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services. It also includes information related to the payment for these services such as claims, eligibility, and enrollment for benefits. We are required by law to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practices with respect to your PHI. We are also required to abide by the terms of this Notice as currently in effect.
This Notice will be followed by the Plan and all of the employees, staff and other individuals who assist in the administration of the Plan. This notice also covers our third party "business associates" who perform various activities for us to provide you benefits and to administer the Plan. Before we disclose any of your PHI to one of our business associates, we will enter into a written contract with them that contains terms to protect the privacy of your PHI.

Uses And Disclosures Of Your Protected Health Information
This Notice sets forth different reasons for which we may use and disclose your PHI. The Notice does not list every possible use and disclosure; however, all of our uses and disclosures of your PHI will fall into one of the following general categories.

1. **For Treatment.** We may disclose your PHI to health care providers who treat you.
2. **For Payment.** We will use your PHI for "payment" purposes. For example, we may use and disclose your PHI so that we may provide reimbursement for health care services you received. We may also use or disclose your PHI to obtain premiums for insurance coverage, to determine whether you are eligible for health benefits or coverage, or to make determinations whether treatment is medically necessary for you.
3. **For Health Care Operations.** We may use and disclose your PHI for purposes of health care operations. These uses and disclosures are necessary to manage the Plan and to make sure that all of its participants receive quality health care. Your PHI may be used to assess the quality of service our staff has provided to you or to help us evaluate the benefits of the Plan. It also may be used to apply for a Medicare Part D subsidy.
4. **Treatment Alternatives and Health Related Benefits.** We may use and disclose your PHI to inform you of or recommend possible treatment alternatives or health related benefits or services that may be available to you.
5. **Plan Sponsor.** We may use and disclose your PHI, as needed, to employees of the Kentucky Retirement Systems who have a need to know your PHI to help administer the Plan and answer your questions about your benefits.

6. **Individuals Involved in Your Health Care or Payment for Your Health Care.** We may disclose your PHI to a parent, if you are a minor, or to a personal representative who is involved in your medical treatment or care. We may also disclose this information to a person who is responsible for your medical bills or otherwise involved in paying for your health care. We will generally try to obtain your written authorization before releasing your PHI to your spouse. However, if you are not present or are incapacitated, we may still release your PHI if a disclosure is in your best interest and directly relevant to the inquiring person's involvement in your health care. In addition, we may use and disclose PHI so that your family can be notified as to your condition, location, or death, or so that care or rescue efforts can be coordinated.
7. **As Required By Law.** We will use and disclose your PHI when required to do so by federal, state or local law, to the extent that such use and disclosure is limited to the relevant requirements of such law.
8. **Judicial and Administrative Proceedings.** We may disclose your PHI in response to a court or administrative order. We may also disclose your PHI in response to a subpoena, discovery request, or other lawful process by another person involved in the dispute, but only if we believe that the party seeking the PHI has made reasonable efforts to tell you about the request or to obtain an order protecting the information requested.
9. **Public Health Activities.** We may disclose your PHI for purposes of public health activities. These activities generally include activities such as: preventing or controlling disease, injury, or disability; reporting the conduct of public health surveillance, investigations, and interventions; reporting adverse events relating to product defects, problems, or biological deviations; and notifying people to enable product recalls, repairs, and replacement.
10. **Abuse, Neglect, or Domestic Violence.** We may disclose PHI to notify an appropriate government authority if we reasonably believe an individual has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
11. **Health Oversight Activities.** We may disclose your PHI to a health oversight agency for activities that are necessary for the government to monitor the health care system, government benefit programs, compliance with program standards, and compliance with civil rights laws. These activities might include: civil, administrative or criminal investigations, proceedings, and prosecutions and audits of the Plan by governmental agencies.
12. **Law Enforcement.** We may disclose your PHI, within limitations, if asked to do so by a law enforcement official for a law enforcement purpose, if it is: (1) to identify or locate a suspect, fugitive, material witness, or missing person; (2) about the victim of a crime if the individual agrees to the disclosure, or due to incapacity or emergency, we are unable to obtain the individual's agreement; (3) about a death we suspect may have resulted from criminal conduct; and (4) about criminal conduct we believe in good faith to have occurred on our premises.
13. **Coroners, Medical Examiners and Funeral Directors.** We may disclose your PHI to a coroner or medical examiner as necessary to identify a deceased person or determine a cause of death. We may also disclose your PHI, as necessary, in order for the funeral directors to carry out their duties.
14. **Organ, Eye and Tissue Donation.** We may disclose your PHI to an organ procurement organization or other entity involved in the procurement, banking, or transplantation of organs, eyes, or tissue to facilitate the donation and transplantation process.
15. **Research.** We may use and disclose your PHI for certain limited research purposes. Generally, the research project must be approved through a special committee that reviews the research proposal and ensures that the PHI is necessary for research purposes.
16. **To Avert a Serious Threat to Health or Safety.** We may use and disclose your PHI when we believe in good faith it is necessary to prevent a serious threat to your health and safety or the health and safety of another person or the public. Any disclosure, however, would only be to a person able to help prevent the threat.

17. **Governmental Functions.** We may disclose the PHI of individuals who are members of the Armed Forces, as required by appropriate military command authorities. PHI may be disclosed for purposes of determining an individual's eligibility for or entitlement to benefits under appropriate military laws. We may also disclose the PHI of foreign military personnel to the appropriate foreign military authority. We may disclose your PHI to authorized federal officials for lawful intelligence, counterintelligence, and other national security activities as authorized by law. We may disclose your PHI to authorized federal officials, so they may adequately provide protection to the President, other authorized persons, or foreign heads of state. PHI may also be disclosed to conduct special investigations.
18. **Inmates.** We may disclose your PHI, as long as you are an inmate of a correctional institution or under the custody of a law enforcement official, to the correctional institution or law enforcement official. The disclosure must be necessary: (1) for the institution or law enforcement official to provide you with health care; (2) to protect your health and safety or the health and safety of others in connection with the correctional institution; and (3) for the safety and security of the correctional institution.
19. **Workers' Compensation.** We may disclose your PHI for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
20. **Other Uses and Disclosures Of Your Protected Health Information.** Other uses and disclosures of your PHI not covered by this Notice or the laws that apply to us, will be made only with your written authorization. If you have given us your authorization, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose the PHI for the reasons covered by your written authorization, except to the extent that we have taken action in reliance on your authorization. Please note that we are unable to withdraw any disclosures we have already made with your written authorization.

Your Rights Regarding Your Protected Health Information. You have the following rights regarding your PHI which we maintain, as required by law. To exercise any of the following rights, you must make your request in writing by filling out the appropriate form provided by the Plan and submitting it to General Counsel, Kentucky Retirement Systems, Perimeter Park West, 1260 Louisville Road, Frankfort, KY 40601, (502) 696-8800.

Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure of your PHI for purposes of treatment, payment, or health care operations. You also have the right to request that we restrict the disclosure of your PHI from those involved in your health care or the payment for your health care, such as with a family member or friend. For example, you may request that we not use or disclose your PHI relating to a procedure you may have had. We are not required to agree with your request for restrictions. However, if we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. If we agree to your request, either you or we may revoke the restriction; however, if we revoke it, it will only apply to PHI that we obtain after the revocation. The only instance in which we must agree to a restriction is when you request to restrict a disclosure to another health plan for purposes of carrying out payment or health care operations (and not for purposes of carrying out treatment), provided your health information pertains solely to a health care item or service for which a health care provider involved has been paid out of pocket in full. In your request, you must tell us: (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse or children.

Right to Request Confidential Communications. You have the right to request that we communicate with you about your personal health matters in a particular way or at a particular location.
For example, you can request that we only contact you at work or at a friend's house. We may require that your request contain a statement that the disclosure of all or part of the PHI for which you are requesting a restriction could harm you if disclosed. We will accommodate all reasonable requests. However, we may condition granting your request on receiving appropriate information regarding payment, as well as you specifying how or where you would like us to contact you.

Right to Inspect and Copy. You have the right to inspect and copy your PHI that is kept in a designated record set. This may include medical and billing records, but does not include: (1) psychotherapy notes; (2) information compiled in anticipation of or for use in legal actions or proceedings; or (3) PHI that is maintained by the Plan to which access is prohibited by law. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or preparing the requested documents.
We may provide you with a written denial of your request to inspect and copy in certain very limited circumstances: (1) the PHI you are requesting to inspect is specifically prohibited by law; or (2) the information you are requesting was confidentially obtained from a source other than a health care provider and if you were granted access you could find out the identity of the source.

If you are denied access to your PHI, for reasons other than those listed above, you may request that the denial be reviewed. A licensed health care professional chosen by the Plan will review your request, as well as the basis for the denial. The person conducting the review will not be the person who denied your request the first time. The outcome of the review will be the final decision.

Right to Amend. You have the right to request that we amend your PHI in a designated record set if it is incorrect or incomplete. You have the right to request an amendment for as long as the information is kept by or for the Plan within a designated record set. You must be prepared to provide a reason to support your request for an amendment.

We may deny your request for an amendment if the request does not include a reason to support the request for an amendment. Furthermore, we may deny your request for an amendment if you request that we amend PHI that: (1) was not created by us, unless the person or covered entity that created the PHI is no longer available to make the amendment; (2) is not part of the health information kept by or for the Plan within the designated record set; (3) is not part of the information that you would be permitted to inspect and copy by law; or (4) is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request a list of the disclosures we have made of your PHI. Your request must state a time period that may not be longer than six years, but that may be shorter, and may not include dates before September 1, 2005. The first accounting you request within a 12 month period will be free. For additional accountings, we may charge you for the costs of providing the accounting. We will notify you of the costs involved and give you an opportunity to withdraw or modify your request, before any costs have been incurred. You have a right to receive an accounting of disclosures made by the Plan within the past six years from the date of your request, except for disclosures that have been made: (1) to carry out treatment, payment or health care operations; (2) to you; (3) incident to a use or disclosure permitted or required by law; (4) pursuant to an authorization; (5) to those involved in your care or for notification purposes; (6) for national security or intelligence purposes; (7) to correctional institutions or law enforcement officials; (8) as part of a limited data set; and (9) prior to September 1, 2005.

Right to a Paper Copy of this Notice. You have the right to receive a paper copy of this Notice. You may request that we give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to receive a paper copy.

Receive Notice of a Breach. You have the right to be notified in writing following a breach of your medical information that is not secured in accordance with certain security standards.

Changes To This Notice. We reserve the right to change the terms of this Notice. We reserve the right to make the new Notice provisions effective for all PHI we currently maintain, as well as any information we receive in the future.

Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Plan or with the Secretary of the Department of Health and Human Services. You will not be retaliated against or penalized for filing the complaint. To file a complaint with the Plan, contact the Privacy Officer, Kentucky Retirement Systems, Perimeter Park West, 1260 Louisville Road, Frankfort, KY 40601. You will need to submit your complaint in writing. The Privacy Officer or designated staff will review and investigate your complaint and provide you with a written response within 30 days, or within 60 days if additional time is needed. You will be notified in writing if additional time is needed. If you wish to have your complaint further reviewed after receiving the written response, you may contact the KRS General Counsel to request additional review and action on y our complaint. You may request review directly by the General Counsel if you have requested access or amendment and your request has been denied. To request additional review contact KRS General Counsel, Kentucky Retirement Systems, 1260 Louisville Road, Frankfort, KY 40601. You will receive written notification within 30 days or 60 days if additional time is needed and you are notified of the delay regarding the review of your claim.

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.

COBRA Continuation Coverage

This section contains important information about *your* right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to continuation of coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to *you* and to other members of *your* family who are covered under the Plan when *you* would otherwise lose *your* group health coverage. This section generally explains COBRA continuation coverage, when it may become available to *you* and *your* family, and what *you* need to do to protect the right to receive it. This section gives only a summary of *your* COBRA continuation coverage rights. For more information about *your* rights and obligations under the Plan and under federal law, contact the Plan Administrator.

The Plan Administrator is:

KENTUCKY RETIREMENT SYSTEMS
Perimeter Park West
1260 Louisville Road
Frankfort, Kentucky 40601-6124,
Telephone 1-800-928-4646.

The Plan Administrator is responsible for administering COBRA continuation coverage.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this section. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." Only qualified beneficiaries may elect to continue their group health plan coverage under the Plan. A qualified beneficiary is a retiree, spouse of a retiree, or *dependent* of a retiree who will lose coverage under the Plan because of a qualifying event. (Certain newborns, newly adopted children and alternate recipients under Qualified Medical Child Support Orders ["QMCSOs"] may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.) Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Continuation coverage is the same coverage that the Plan makes available to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including special enrollment rights. For more information about *your* rights and obligations under the Plan, contact the Plan Administrator.

Qualifying Events

If *you* are a retiree, *you* will become a qualified beneficiary if *you* lose *your* coverage under the Plan because *your* retirement benefits end within the COBRA maximum coverage period for any reason other than *your* gross misconduct. If *you* are the spouse of a retiree, *you* will become a qualified beneficiary if *you* lose *your* coverage under the Plan because any of the following qualifying events:

1. *Your* spouse dies;
2. *Your* spouse's retirement benefits end within the COBRA maximum coverage period for any reason other than his or her gross misconduct;
3. *Your* spouse becomes enrolled in Medicare (Part A, Part B or both); or
4. *You* become divorced or legally separated from *your* spouse. *Your dependent* children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happen:
5. The parent-retiree dies;
6. The parent-retiree's retirement benefits end within the COBRA maximum coverage period for any reason other than his or her gross misconduct;
7. The parent-retiree becomes enrolled in Medicare (Part A, Part B or both);
8. The parents become divorced or legally separated; or
9. The child stops being eligible for coverage under the Plan as a "*dependent* child."

Notification Of Qualifying Events

You are responsible for providing notice to the Plan Administrator when certain qualifying events occur. If *you* do not provide notice within certain timeframes, *you* will not be entitled to continuation coverage under the Plan. The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been timely notified that a qualifying event has occurred. When the qualifying event is the death of the retiree, or enrollment of the retiree in Medicare (Part A, Part B or both), the retiree or the retiree's family must notify the Plan Administrator of such qualifying event as soon as possible, but not later than 30 days of any of these events. For the other qualifying events including:

(1) divorce or legal separation of the retiree and spouse,
(2) a *dependent* child's losing coverage,
(3) the occurrence of a second qualifying event, or
(4) determination of Social Security disability status, *you*, the affected qualified beneficiary, or *your* representative must notify the Plan Administrator.

The Plan requires *you* to notify the Plan Administrator in writing within 60 days after the later of

(1) the qualifying event,
(2) the date the qualified beneficiary loses (or would lose) coverage due to the qualifying event, or
(3) the date the qualified beneficiary is informed of the responsibility to provide notice and the Plan's procedures for providing notice, using the procedures specified in the section below titled "Notice Procedures." If these procedures are not followed, or if the notice is not provided in writing to the Plan Administrator during the 60-day notice period, any spouse or *dependent* child who loses coverage will NOT BE OFFERED THE OPTION TO ELECT CONTINUATION COVERAGE.

Notice Procedures

Any notice that *you* provide must be in writing. Oral notice, including notice by telephone, is not acceptable. *You* must mail or hand deliver *your* notice to:

KENTUCKY RETIREMENT SYSTEMS
Perimeter Park West, 1260 Louisville Road,
Frankfort, Kentucky 40601-6124.

If mailed, *your* notice must be postmarked no later than the last day of the required notice period. Any notice *you* provide must state the name and address of the retiree covered under the Plan, and the name(s) and address(es) of the qualified beneficiary(ies). *Your* notice also must name the qualifying event and the date it happened. The Plan's form of Notice Of Qualifying Event should be used to notify KENTUCKY RETIREMENT SYSTEMS of a qualifying event. A copy of this form can be obtained from the Plan Administrator. If the qualifying event is a divorce, *your* notice must include a copy of the divorce decree. *Your* notice of a second qualifying event also must name the event and the date it happened. If the qualifying event is a divorce, *your* notice must include a copy of the divorce decree. *Your* notice of disability also must include the name of the disabled qualified beneficiary, the date when the qualified beneficiary became disabled and the date the Social Security Administration made its determination. *Your* notice of disability must include a copy of the Social Security Administration's determination. The Plan's form of Notice by Qualified Beneficiary should be used to notify KENTUCKY RETIREMENT SYSTEMS of a second qualifying event, a disability determination or a determination that a qualified beneficiary is no longer disabled. A copy of this form can be obtained from the Plan Administrator.

Electing COBRA Continuation Coverage

Once the Plan Administrator receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who timely elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost. Each qualified beneficiary has an independent right to elect continuation coverage. For example, both the retiree and the retiree's spouse (if he or she had been covered under the Plan on the day before the qualifying event) may elect continuation coverage, or only one of them may. Parents may elect to continue coverage on behalf of their *dependent* children only. A qualified beneficiary must elect coverage in writing within 60 days of being provided a COBRA election notice, using the Plan's election form and following the procedures specified on the election form. A copy of the Plan's election form may be obtained from the Plan Administrator. *Your* written notice must be provided to the Plan Administrator at the address provided on the Plan's election form. If *you* mail *your* election, it must be postmarked no later than the last day of the 60-day election period. If *you* or *your* spouse or *dependent* children do not elect continuation coverage within the 60-day election period,

YOU WILL LOSE YOUR RIGHT TO ELECT CONTINUATION COVERAGE.

A qualified beneficiary may change a prior rejection of continuation coverage at any time until the end of the 60-day election period, in writing, by using the election form and following the procedures specified on the election form.

Failure to Elect

In considering whether to elect continuation coverage, *you* should take into account that a failure to continue *your* group health coverage will affect *your* future rights under federal law. First, *you* may lose the right to avoid having pre-existing condition exclusions applied to *you* by other group health plans if *you* have more than a 63-day gap in health coverage, and election of continuation coverage may help *you* not have such a gap. Second, *you* may lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if *you* do not get continuation coverage for the maximum time available to *you*. Finally, *you* should take into account that *you* may have special enrollment rights under federal law. *You* may have the right to request special enrollment in another group health plan for which *you* are otherwise eligible (such as a plan sponsored by *your* spouse's employer) within 30 days after *your* group health coverage ends because of a qualifying event. *You* may also have the same special enrollment right at the end of the continuation coverage if *you* get continuation coverage for the maximum time available to *you*.

Length of COBRA Continuation Coverage

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the retiree, enrollment of the retiree in Medicare (Part A, Part B or both), *your* divorce or legal separation, or a *dependent* child losing eligibility as a *dependent* child, COBRA continuation coverage lasts for up to 36 months. When the qualifying event is an end to retirement benefits within the COBRA maximum coverage period for any reason other than a retiree's gross misconduct, COBRA continuation coverage lasts for up to 18 months. There are three ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of Continuation Coverage

An 11-month extension of coverage maybe available if any of the qualified beneficiaries in *your* family is disabled. All of the qualified beneficiaries who have elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. The Social Security Administration (SSA) must determine that the qualified beneficiary was disabled at some time during the first 60 days of continuation coverage, and *you* must notify KENTUCKY RETIREMENT SYSTEMS of that fact in writing, using the procedures specified in the previous section titled "Notice Procedures," within 60 days after the later of:

(1) the date of the SSA's determination,
(2) the date of the qualifying event,
(3) the date on which the qualified beneficiary loses Plan coverage due to the qualifying event or
(4) the date the qualified beneficiary is informed of the responsibility to provide notice and the Plan's procedures for providing notice, and before the end of the first 18 months of continuation coverage.

If these procedures are not followed or if a written notice of a disability is not provided to the Plan Administrator within the required period, THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA CONTINUATION COVERAGE. If the qualified beneficiary is determined by the SSA to no longer be disabled, *you* must notify KENTUCKY RETIREMENT SYSTEMS of that fact within 30 days of the later of SSA's determination or the date the qualified beneficiary is informed of such responsibility to provide notice, using the procedures specified in the previous sections titled "Notification Of Qualifying Events" and "Notice Procedures." COBRA coverage for all qualified beneficiaries will terminate as of the first day of the month that is more than 30 days after the SSA's determination that the qualified beneficiary is no longer disabled, but no sooner than 18 months after the date of the original qualifying event. The Plan reserves the right to retroactively cancel COBRA coverage and will require reimbursement of all benefits paid after the first day of the month that is more than 30 days after the SSA's determination that the qualified beneficiary is no longer disabled.

Second qualifying event extension of 18-month period of continuation coverage

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 events include a loss of Plan coverage due to

(1) the death of a covered retiree,
(2) divorce or separation from the covered retiree,
(3) the covered retiree enrolling in Medicare, or
(4) a *dependent* child's ceasing to be eligible for coverage as a *dependent* under the Plan.

Upon the occurrence of a second qualifying event, *you* must notify KENTUCKY RETIREMENT SYSTEMS in writing within 60 days after the second qualifying event occurs using the procedures specified in the previous sections titled "Notification Of Qualifying Events" and "Notice Procedures." If these procedures are not followed, or of a written notice of a second qualifying event is not provided to the Plan Administrator within the required period, THEN THERE WILL BE NO EXTENSION OF COBRA CONTINUATION COVERAGE DUE TO A SECOND QUALIFYING EVENT. Medicare extension for spouse and *dependent* children

If a qualifying event that is an end to the retiree's retirement benefits within the COBRA maximum coverage period for any reason other than the retiree's gross misconduct occurs within 18 months after the retiree becomes entitled to Medicare, then the maximum coverage period for the spouse and *dependent* children will end 36 months from the date the retiree became entitled to Medicare (but the retiree's maximum coverage period will be 18 months).

Termination of COBRA Continuation Coverage before the End of the Maximum Coverage Period
Continuation coverage will be terminated before the end of the maximum period if

(1) any required premium is not paid on time;
(2) after electing COBRA coverage, a qualified beneficiary becomes covered under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary;
(3) after electing COBRA coverage, a qualified beneficiary enrolls in Medicare; or
(4) KENTUCKY RETIREMENT SYSTEMS ceases to provide any group health plan for its members.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of participant or beneficiary not receiving continuation coverage (such as fraud). *You* must notify the Plan Administrator in writing within 30 days if, after electing COBRA coverage, a qualified beneficiary becomes covered under another group health plan or enrolls in Medicare Part A or B. You must use the notice procedures specified in the previous sections titled "Notification of Qualifying Events".

"Notice Procedures." The Plan reserves the right to retroactively cancel COBRA coverage and, in that case, will require reimbursement of all benefits paid after the date of commencement of other group health plan coverage or Medicare entitlement.

Cost of Continuation Coverage

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% of the cost to the group health plan for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage (or, in the case of an extension of continuation coverage due to a disability, 150%). The Trade Act of 2002 created a new tax credit for certain individuals who become 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. More information about the Trade Act is available at www.doleta.gov/tradeact.

Payment for Continuation Coverage

First payment for continuation coverage if *you* elect continuation coverage, *you* do not have to send any payment for continuation coverage with the election form. However, *you* must make *your* first payment for continuation coverage within 45 days after the date of *your* election. This is the date the election form is postmarked, if mailed. If *you* do not make *your* first payment for continuation coverage within those 45 days, *you* will lose all continuation coverage rights under the Plan. *Your* first payment must cover the cost of continuation coverage from the time *your* coverage under the Plan would have otherwise terminated. *You* are responsible for making sure that the amount of *your* first payment is enough to cover this entire period. KRS has contracted with Discovery Benefits to administer COBRA benefits for the Plan. The COBRA premium payment amounts and the mailing address for the COBRA premiums will be stated on the election form provided to *you* at the time of *your* COBRA qualifying event. Questions concerning premium payments should be directed to Discovery Benefits at1- 877-765-8810. .

Periodic Payments for Continuation Coverage

After *you* make *your* first payment for continuation coverage, *you* will be required to pay for continuation coverage for each subsequent month of coverage. Under the Plan, these periodic payments for continuation coverage are due on the first day of the month for the month in which the payments apply. If *you* make a periodic payment on or before its due date, *your* coverage under the Plan will continue for that coverage period without any break. The Plan will not send periodic notices of payments due for these coverage periods. Periodic payments for continuation coverage should be sent to the address indicated on the election form provided at the time of *your* COBRA qualifying event.

Grace Periods for Periodic Payments

Although periodic payments are due on the dates shown above, *you* will be given a grace period of 30 days to make each periodic payment. *Your* continuation coverage will be provided for each coverage period so long as payment for that coverage period is made before the end of the grace period for that payment. If *you* fail to make a periodic payment before the end of the grace period for that payment, *you* will lose all rights to continuation coverage under the Plan. The grace period does not apply to *your* first payment which is due 45 days after the date of *your* election.

Option to Elect Other Health Coverage Besides COBRA Continuation Coverage

You may have the right, when *your* group health coverage ends, to enroll in an individual health insurance policy, without providing proof of insurability. The benefits provided under such an individual conversion policy may not be identical to those provided under the Plan. *You* may exercise this right in lieu of electing continuation coverage, or *you* may exercise this right after *you* have received the maximum continuation coverage available to you. You should note that if you enroll in an individual conversion policy, you could lose your right under federal law to purchase individual health insurance that does not impose any pre-existing condition limitations when your conversion policy coverage ends.

More Information About Individuals Who May Be Qualified Beneficiaries Children born to or placed for adoption with the covered retiree during COBRA period

A child born to, adopted by or placed for adoption with a covered retiree during a period of continuation coverage is considered to be a qualified beneficiary provided that, if the covered retiree is a qualified beneficiary, the covered retiree has elected continuation coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the retiree. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

Alternate recipients under QMCSOs

A child of the covered retiree who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) is entitled to the same rights under COBRA as a *dependent* child of the covered retiree. The covered retiree must properly designate the child who is receiving benefits under the Plan pursuant to a QMCSO as a *dependent* with KENTUCKY RETIREMENT SYSTEMS.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact
KENTUCKY RETIREMENT SYSTEMS
Perimeter Park West, 1260 Louisville Road
Frankfort, Kentucky 40601-6124
Telephone: 1-800-928-4646

Or you may contact the U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services Web site at www.cms.gov.

PLAN CONTACT INFORMATION

Discovery Benefits
3216 13th Ave. S
Fargo, ND 58103
Telephone: 1-877-765-8810

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

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

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

Contact *your* Kentucky Retirement Systems (KRS) if *you* would like more information on WHCRA benefits.

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).

Contact *your* Kentucky Retirement Systems (KRS) if *you* would like more information on The Newborns' and Mothers' Health Protection Act.

PLAN DESCRIPTION INFORMATION

1. Proper Name of Plan: Kentucky Retirement Systems Medical Only Plan

2. *Plan Sponsor*: Kentucky Retirement Systems
   1260 Louisville Road
   Frankfort, KY 40601
   Telephone: 1-502-696-8800

3. *Employer*: Commonwealth of Kentucky DBA Kentucky Retirement Systems
   1260 Louisville Road
   Frankfort, KY 40601
   Telephone: 1-502-696-8800

   Common Name of *Employer*: Kentucky Retirement Systems

4. *Plan Administrator* and Named Fiduciary:

   Board of Trustees of the Kentucky Retirement Systems
   1260 Louisville Road
   Frankfort, KY 40601
   Telephone: 1-502-696-8800

5. Kentucky Retirement Systems (KRS) Identification Number: 61-0600439

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

7. Plan benefits described in this booklet are effective January 1, 2016.

8. The *Plan year* is January 1through 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:

    Legal Department
    1260 Louisville Road
    Frankfort, KY 40601

11. The *Plan Manager* is responsible for performing certain delegated administrative duties, including the processing of claims. The *Plan Manager* and Claim Fiduciary are:

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

12. This is a self-insured and self-administered health benefit plan. The cost of this Plan is paid with contributions shared by the Kentucky Retirement Systems (KRS) and *covered member*. Benefits under this Plan are provided from the general assets of the Kentucky Retirement Systems (KRS) and are used to fund payment of covered claims under this Plan plus administrative expenses. Please see *your* Kentucky Retirement Systems (KRS) 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 *covered member* of the Kentucky Retirement Systems (KRS) who participates in this Plan receives a *Summary Plan Description*, which is this booklet. This booklet will be provided to *covered members* by the Kentucky Retirement Systems (KRS). It contains information regarding eligibility requirements, termination provisions, a description of the benefits provided and other Plan information.

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*. 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 *covered members* 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 Kentucky Retirement Systems (KRS) and any *covered person* and will not be considered as an inducement or condition of the employment of any *covered member*. Nothing in this Plan will give any *covered member* the right to be retained in the service of the Kentucky Retirement Systems (KRS), or for the Kentucky Retirement Systems (KRS) to discharge any *covered member* at any time.

17. This Plan is not in lieu of and does not affect any requirement for coverage by workers' compensation insurance.

SECTION 6

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 benefit determination means a denial, reduction, or termination, or failure to provide or make payment (in whole or in part) for a benefit, including:

1. A determination based on a *covered person's* eligibility to participate in this Plan;

2. A determination that a benefit is not a covered benefit;

3. The imposition of a source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits; or

4. A determination resulting from the application of any utilization review, such as the failure to cover an item or *service* because it is determined to be experimental/investigational or not *medically necessary*.

An *adverse benefit determination* includes any rescission of coverage (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time). Rescission is a cancellation or discontinuance of coverage that has retroactive effect. A cancellation or discontinuance is not a rescission if:

1. The cancellation or discontinuance of coverage has only a prospective effect; or

2. 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.

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*.

Applied behavioral analysis (ABA) therapy is an intensive behavioral treatment program that attempts to improve cognitive and social functioning.

B

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.

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.

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 Kentucky Retirement Systems (KRS) to provide specific COBRA administrative services.

Coinsurance means the shared financial responsibility for *covered expenses* between the *covered person* and this Plan, expressed as a percentage.

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.

Copayment means the specified dollar amount that *you* must pay to a provider for certain medical *covered expenses* regardless of any amounts that may be paid by this Plan as shown in the Medical Schedule of Benefits section.

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

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

Covered expense 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.

Covered person means the *covered member* or any of the *covered member's* 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 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 a covered *covered member's*:

1. Legally recognized spouse;

2. Natural blood related child, step-child, legally adopted child or child placed with the *covered member* for adoption, foster child, or child for which the *covered member* has legal guardianship, whose age is less than the limiting age.

   The limiting age for each *dependent* child is the end of the birth month he or she attains the age of 26 years. *Your* child is covered to the limiting age regardless if the child is:
   a. Married;
   b. A tax dependent;
   c. A student;
   d. Employed; or
   e. Residing with or receives financial support from *you*.

3. A covered *covered member's* child whose age is less than the limiting age and is entitled to coverage under the provisions of this Plan because of a medical child support order.

You must furnish satisfactory proof, upon request, to Humana that the above conditions continuously exist. If satisfactory proof is not submitted to Humana, the child's coverage will not continue beyond the last date of eligibility.

A covered *dependent* child who attains the limiting age while covered under this Plan will remain eligible for benefits if all of the following exist at the same time:

1. Permanently mentally disabled or permanently physically handicapped;

2. Incapable of self-sustaining employment;

3. The child meets all of the qualifications of a *dependent* as determined by the United States Internal Revenue Service;

4. Declared on and legally qualify as a *dependent* on the *covered member's* federal personal income tax return filed for each year of coverage; and

5. Unmarried.

You must furnish satisfactory proof to Humana that the above conditions continuously exist on and after the date the limiting age is reached. Humana may not request such proof more often than annually after two years from the date the first proof was furnished. If satisfactory proof is not submitted to Humana, the child's coverage will not continue beyond the last date of eligibility.

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.

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

***Emergency* (true)** means an acute, sudden onset of a *sickness* or *bodily injury* which is life threatening or will significantly worsen without immediate medical or surgical treatment.

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 means a drug, biological product, device, treatment or procedure that meets any one of the following criteria, as determined by this Plan:

1. Cannot be lawfully marketed without the final approval of the United States Food and Drug Administration (FDA) and which lacks such final FDA approval for the use or proposed use, unless:

    a. Found to be accepted for that use in the most recently published edition of Clinical Pharmacology, Micromedex DrugDex, National Comprehensive Cancer Network Drugs and Biologics Compendium, and the American Hospital Formulary Service (AHFS) Drug Information for drugs used to treat cancer, and is determined to be covered 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 and Off-Label and Off-Evidence); or

b. Found to be accepted for that use in the most recently published edition of the Micromedex DrugDex or AHFS Drug Information for non-cancer drugs, and is determined to be covered 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 and Off-Label and Off-Evidence); or

c. Identified by this Plan as safe, widely used and generally accepted as effective for that use as reported in nationally recognized peer reviewed medical literature published in the English language as of the date of service;

2. Is a device required to receive Premarket Approval (PMA) or 510K approval by the FDA but has not received a PMA or 510K approval;

3. Is not identified as safe, widely used and generally accepted as effective for the proposed use as reported in nationally recognized peer reviewed medical literature published in the English language as of the date of service;

4. Is the subject of a National Institute of Health (NIH) Phase I, II or III trial or a treatment protocol comparable to a NIH Phase I, II or III trial, or any trial not recognized by NIH regardless of phase, except for:

   a. Clinical trials 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 and Off-Label and Off-Evidence); or

   b. Transplants, in which case this Plan would approve requests for *services* that are the subject of a NIH Phase II, Phase III or higher when transplant *services* are appropriate for the treatment of the underlying disease;

5. Is identified as not covered by the Centers for Medicare and Medicaid Services (CMS) Medicare Coverage Issues Manual, a CMS Operational Policy Letter or a CMS National Coverage Decision, except as required by federal law and excluding transplants.

External review means a review of an *adverse benefit determination* (including a *final internal adverse benefit determination*) conducted pursuant to the federal *external review* process or an applicable state *external review* process.

F

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

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

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*;

4. Is primarily engaged in providing diagnostic and therapeutic facilities for medical or surgical care of sick or injured persons;

5. Is legally operated in the jurisdiction where located; and

6. Has surgical facilities on its premises or has a contractual agreement for surgical *services* with an institution having a valid license to provide such surgical *services*; or

7. Is a lawfully operated *qualified treatment facility* certified by the First Church of Christ Scientist, Boston, Massachusetts.

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*.

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.

L

Late applicant means a *covered member* and/or a *covered member's* eligible *dependent* who applies for medical coverage more than 31 days after the eligibility date.

Lifetime maximum benefit means the maximum amount of benefits available while *you* are covered under this Plan.

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 "Medical Schedule of Benefit"s section. No further benefits are payable once the *maximum benefit* is reached.

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

1. Performed in the least costly setting required by *your* condition;

2. Not provided primarily for the convenience of the patient or the *qualified practitioner*;

3. Appropriate for and consistent with *your* symptoms or diagnosis of the *sickness* or *bodily injury* under treatment;

4. Furnished for an appropriate duration and frequency in accordance with accepted medical practices, and which are appropriate for *your* symptoms, diagnosis, *sickness* or *bodily injury*; and

5. Substantiated by the records and documentation maintained by the provider of *service*.

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

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.

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.

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.

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 custom-fitted or custom-made braces, splints, casts, supports and other devices used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body when prescribed by a *qualified practitioner*.

Out-of-pocket limit 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.

P

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.

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

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

Plan Administrator means Board of Trustees of the Kentucky Retirement Systems.

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 Kentucky Retirement Systems.

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.

Preauthorization (also known as "*preauthorization*") means the process of assessing the *medical necessity*, appropriateness, or utility of proposed non-emergency *hospital admission*s, surgical procedures, outpatient care, and other health care *services*.

Predetermination of benefits means a review by Humana of a *qualified practitioner's* treatment plan, specific diagnostic and procedure codes and expected charges prior to the rendering of *services*.

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.

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 contract means a legally binding agreement between Humana and a *participating provider* that includes a provider payment arrangement.

Q

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.

R

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.

Retail Clinic means a *qualified treatment facility*, located in a retail store, that is often staffed by nurse practitioners and physician assistants who provide minor medical services on a "walk-in" basis (no appointment required).

Retiree means *you* as a former *covered member*, who meets the requirements for retirement as determined by *your* Kentucky Retirement Systems (KRS).

Retrospective review means a review conducted after *services* (including outpatient procedures and *services*) have been provided to a *covered person* to validate utilization decisions and/or payment made for the care that was provided.

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.

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.

Specialist means a *qualified practitioner* who has received training in a specific medical field other than those listed as primary care.

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

4. 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.

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 any body opening, natural or otherwise, done for diagnostic or other therapeutic purposes.

T

Timely applicant means a *covered member* and/or a *covered member's* eligible *dependent* who applies for medical coverage within 31 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.

U

Urgent care claim means any claim for medical care or treatment when the time periods for making non-urgent care determinations:

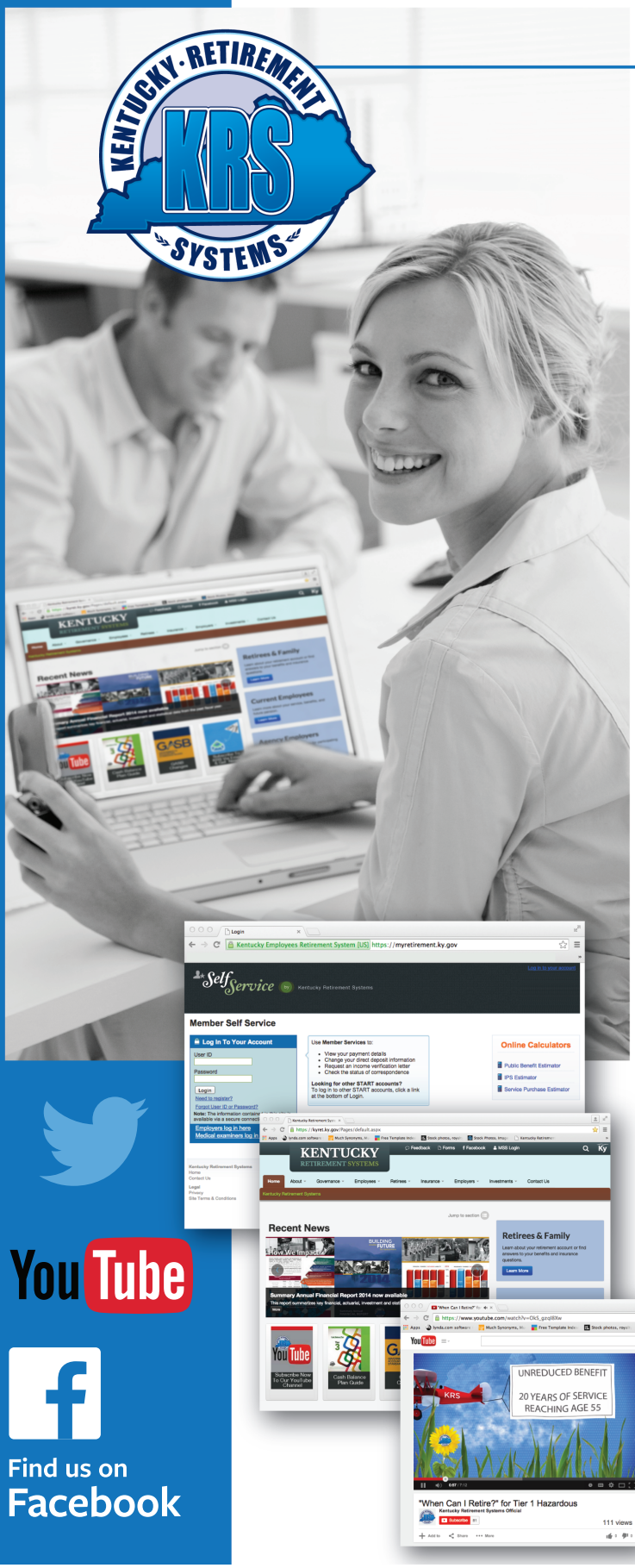
1. Could seriously jeopardize the life or health of the *claimant* or the ability of the *claimant* to regain maximum function; or

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.

Y

You and your means any *covered person.*

YOUR RESOURCES



Our Website

https://kyret.ky.gov

- **Links to Member Education Videos**
- **Member Forms and Directions**
- **News & Updates**
- **Publications** *(Recent and Archive)*
- **Contacting Us**

Self Service

MyRetirement.ky.gov

- **Update your personal information**
- **Calculate your benefits**
- **Get your retirement information**

Member Education

Videos located at youtube.com/user/KentuckyRetire

- **Video Library**

  How-to Videos

  How to Retire
  How to fill out form 6000
  How to Calculate Your Benefit
  ...and more!

- **Webinars**
  (interact and ask questions)
- **Town Hall**
  (the latest information and what it means to you)
- **On-location Outreach**

Member Communications

www.Facebook.com/kyretirement
Twitter - @KYretire

- **Up-to-date information as it happens**
- **New releases of videos & publications**
- **Instant notification of Webinars**

Retirement Counselors

- **Call Center**
  Monday - Friday 8:00am - 4:30pm
  1-502-696-8800 or 1-800-928-4646
- **On-site Counselors**
  Perimeter Park West
  1260 Louisville Road
  Frankfort, KY 40601
- **Email**
  krs.mail@kyret.ky.gov
  General Questions only (unsecure)

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