

Attached is the most recent copy of your Plan Booklet.

Please disregard any prior booklets you have received.

**This booklet is valid from
July 1, 2006 through December 31, 2006.**

Thank you,

Humana Inc.

UNIVERSITY OF KENTUCKY

**CARVE-OUT
INDEMNITY PLAN**

GROUP NUMBERS:

M1237

Effective July 1, 2006

Privacy of Health Information

By acceptance of coverage under this Summary Plan Description, a participant consents to the University of Kentucky and/or Humana Insurance Company and/or its subsidiaries using and disclosing your health information in order to provide you with benefit coverage under the University of Kentucky Medical Benefits Plan. Except for those disclosures permitted or required by law, University of Kentucky and/or Humana Insurance Company and/or its subsidiaries will not release identifiable protected health information unless specifically authorized by the participant or by an authorized person on the participant's behalf. If an participant's authorization is needed to obtain health information required for a benefit determination, the University of Kentucky and/or Humana Insurance Company and/or its subsidiaries may request the participant's specific authorization. Benefit coverage may be denied if health information necessary for a benefit determination is not disclosed.

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PLAN DESCRIPTION INFORMATION

1. Proper Name of Plan: University of Kentucky
Common Name of Plan: University of Kentucky
2. Plan Sponsor: University of Kentucky
3. Plan Administrator and Named Fiduciary -

University of Kentucky
115 Scovell Hall
Lexington, KY 40506-0064
Telephone: (859) 257-9519 ext. 172
4. *Employer* Identification Number: 61-6001218
5. The Plan provides medical and prescription drug benefits for eligible *participants* and their enrolled *dependents*.
6. Plan benefits described in this booklet are effective July 1, 2006.
7. The *Plan year* and fiscal year are July 1 through June 30 of each year.
8. Agent for service of legal process:

University of Kentucky
115 Scovell Hall
Lexington, KY 40506-0064
Telephone: (859) 257-9519 ext. 172
9. The *Plan Manager* is responsible for performing certain delegated administrative duties, including the processing of claims. The *Plan Manager* is:

Humana
500 West Main Street
Louisville, KY 40202
Toll Free: 1-877-857-1681
10. The Plan's contributions are shared by the *employer* and *participant*. Benefits under the Plan are provided from the general assets of the *employer*.
11. Each *participant* in the Plan receives a Summary Plan Description, which is this booklet. This booklet will be provided to *participants* by the University of Kentucky. It contains information regarding eligibility requirements, termination provisions, a description of the benefits provided, and other Plan information.
12. The Plan benefits and/or contributions may be modified or amended from time to time, or may be terminated at any time by the Plan Sponsor. Significant changes to the Plan, including termination, will be communicated to participants as required by applicable law.

Plan Description Information Continued

13. Upon termination of the Plan, the rights of the participants to benefits are limited to claims incurred and payable by the Plan up to the date of termination. Plan assets, if any, will be allocated and disposed of for the exclusive benefit of the *participants* and their *dependents* covered by the Plan, except that any taxes and administration expenses may be made from the Plan assets.
14. The Plan does not constitute a contract between the *employer* and any *covered person* and will not be considered as an inducement or condition of the employment of any *employee*. Nothing in the Plan will give any *employee* the right to be retained in the service of the *employer*, or for the *employer* to discharge any *employee* at any time.
15. This Plan is not in lieu of and does not affect any requirement for coverage by Workers' Compensation insurance.

Note: Italicized terms within the text are defined in this section of the booklet.

DEFINITIONS

Active status means performing on a regular, basis all customary occupational duties at the *employer's* business locations or when required to travel for the *employer's* business purposes. Each day of a regular paid vacation and any regular non-working holiday will be deemed *active status* if *you* were in an *active status* on *your* last regular working day prior to the vacation or holiday.

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

Case management means the process of assessing whether an alternative plan of care would more effectively provide *medically necessary* health care *services* in an appropriate setting.

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 nonelective 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 does 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 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 means being a resident patient in a *hospital* or a *qualified treatment facility* for at least 15 consecutive hours per day. Successive *confinements* are considered one *confinement* if:

1. Due to the same *bodily injury* or *sickness*; and
2. Separated by fewer than 7 consecutive days when *you* are not confined.

Coinsurance means the shared financial responsibility for *covered expenses* between the *covered person* and the self-insured plan.

Definitions Continued

Copayment (medical) means the amount to be paid by *you* for each applicable medical *service*.

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

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

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

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, toileting, transferring, eating, walking and taking medication. These *services* are considered *custodial care* regardless if a *qualified practitioner* or provider has prescribed, recommended or performed the *services*.

Dental injury is an injury caused by a sudden, violent, and external force that could not be predicted in advance and could not be avoided. *Dental injury* does not include chewing injuries.

Dependent means a covered *participant's*:

1. Legally recognized spouse;
2. Unmarried natural blood related child, stepchild, legally adopted child or child for which the *participant* has legal guardianship whose age is less than the limiting age. Each child must legally qualify as a *dependent* as defined by the United States Internal Revenue Service.

The limiting age for each *dependent* child is 25 years.

Adopted children and children placed for adoption are subject to all terms and provisions of the Plan.

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

You must furnish satisfactory proof to the *Plan Manager* upon request that the above conditions continuously exist. If satisfactory proof is not submitted to the *Plan Manager*, 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 the Plan will remain eligible for benefits if all of the following exist at the same time:

1. Mentally retarded 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;

Definitions Continued

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

You must furnish satisfactory proof to the *Plan Manager* that the above conditions continuously exist on and after the date the limiting age is reached. The *Plan Manager* 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 the *Plan Manager*, the child's coverage will not continue beyond the last date of eligibility.

Diagnostic Test means diagnostic procedures, such as laboratory tests, or x-rays for determining the nature of a condition or disease.

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*.

Emergency 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.

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

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

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

Experimental, investigational or for research purposes:

A *service* is *experimental, investigational or for research purposes* if the *Plan Manager* determines;

1. The *service* cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the *service* is furnished; or
2. The *service* or *your* informed consent document utilized with the *service* was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review and approval; or
3. Reliable evidence shows that the *service* is the subject of on-going phase I or phase II clinical trials; is the research, experimental, study or investigational arm of ongoing phase III clinical trials; or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or

Definitions Continued

4. Reliable evidence shows that the prevailing opinion among experts regarding the *service* is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable evidence will mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same *service*; or the written informed consent used by the treating facility or by another facility studying substantially the same *service*.

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

Free-standing surgical facility means a public or private establishment licensed to perform surgery and which has permanent facilities that are equipped and operated primarily for the purpose of performing *surgery*. It does not provide *services* or accommodations for patients to stay overnight.

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 alcoholism, chemical dependence, or *mental disorders*.

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.

Definitions Continued

Maximum allowable fee for a *service* means the lesser of:

1. The fee most often charged in the geographical area where the *service* was performed;
2. The fee most often charged by the provider;
3. The fee which is recognized as reasonable by a prudent person;
4. The fee determined by comparing charges for similar *services* to a national data base adjusted to the geographical area where the *services* or procedures were performed; or
5. The fee determined by using a national relative value scale. Relative value scale means a methodology that values medical procedures and *services* relative to each other that includes, but is not limited to, a scale in terms of difficulty, work, risk, as well as the material and outside costs of providing the *service*, as adjusted to the geographic area where the *services* or procedures were performed.

Maximum benefit means the maximum amount that may be payable for each *covered person*, for *expense incurred*. The applicable *maximum benefit* is shown on the Schedule of Benefits. 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 Title XVIII, Parts A and B of the Social Security Act, as enacted or amended.

Mental disorder 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.

Out-of-pocket limit means when the amount of combined *covered expenses* paid by *you* and/or all *your* covered *dependents* satisfy the deductible and out-of-pocket limits as shown on the Schedule of Benefits, the *Plan* will pay 100% of *covered expenses* for the remainder of the *plan year*, unless specifically indicated, subject to any *plan year* maximums of the *Plan*.

Participant means any covered person, who is properly enrolled in the plan.

Plan Administrator means the University of Kentucky.

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.

Definitions Continued

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.

Preadmission testing means only those outpatient x-ray and laboratory tests made within seven days before admission as a registered bed patient in a *hospital*. The tests must be for the same *bodily injury* or *sickness* causing the patient to be *hospital* confined. The tests must be accepted by the *hospital* in lieu of like tests made during *confinement*. *Preadmission testing* does not mean tests for a routine physical check-up.

Precertification means the process of assessing the *medical necessity*, appropriateness, or utility of proposed non-emergency *hospital* admissions, surgical procedures, outpatient care, and other health care *services*.

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

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*.

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

1. Provides for support of a covered *participant's* child;
2. Provides for health benefit coverage to the child;
3. Is made under state domestic relations law;
4. Relates to benefits under this Plan; and
5. Is qualified in that it meets the technical requirements of ERISA or applicable state law.

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

Qualified practitioner means a practitioner, professionally licensed by the appropriate state agency to diagnose or treat a *bodily injury* or *sickness*, and who provides *services* within the scope of that license.

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.

Services means procedures, surgeries, exams, 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.

Definitions Continued

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.

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.

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.

Utilization review means the process of assessing the *medical necessity*, appropriateness, or utility of *hospital* admissions, surgical procedures, outpatient care, and other health care *services*. *Utilization review* includes *precertification* and *concurrent review*.

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

SCHEDULE OF BENEFITS

AN IMPORTANT MESSAGE ABOUT YOUR PLAN

Services are subject to all provisions of the Plan, including the limitations and exclusions.

Italicized terms within the text are defined in the Definitions section of this booklet.

PRECERTIFICATION

In most locations, the *Plan Manager* will be performing precertification. In those locations where the *Plan Manager* will be performing precertification, the following applies:

Medical Management is a Utilization/Case Management Program provided by the *Plan Manager*.

The Medical Management team will provide *precertification* as required by *your* Plan. Medical Management recommends calling as soon as possible to receive proper *precertification*. Refer to *your* ID card for the phone number to call for *precertification*.

For Mental Disorders, Alcoholism and Chemical Dependency, *precertification* will be performed by Corp Health.

The following benefits require *precertification*:

PRECERTIFICATION		
BENEFIT	REQUIREMENTS	PENALTY
Inpatient Hospitalization	The <i>Plan Manager</i> must be notified at least 7 days in advance. If the admission is on an <i>emergency</i> basis, the <i>Plan Manager</i> must be notified within 48 hours or the first business day following admission.	If the admission is not <i>precertified</i> , benefits for the <i>hospital</i> or <i>qualified treatment facility</i> will be subject to a 50% penalty. The penalty does not apply to the deductible or out-of-pocket maximums.
Inpatient Mental Disorder, Alcoholism, and Chemical Dependence	Corp Health must be notified at least 7 days in advance. If the admission is on an <i>emergency</i> basis, Corp Health must be notified within 48 hours or the first business day following admission.	If the admission is not <i>precertified</i> , benefits for the <i>hospital</i> or <i>qualified treatment facility</i> will be subject to a 50% penalty. The penalty does not apply to the deductible or out-of-pocket maximums.
Outpatient Mental Disorder, Alcoholism, and Chemical Dependence	Corp Health must be notified at least 7 days in advance.	If outpatient <i>services</i> for mental disorder, alcoholism, and chemical dependence are not <i>precertified</i> , benefits for the <i>hospital</i> or <i>qualified treatment facility</i> will be subject to a 50% penalty. The penalty does not apply to the deductible or out-of-pocket maximums.

PRECERTIFICATION		
BENEFIT	REQUIREMENTS	PENALTY
Skilled Nursing Facility	The <i>Plan Manager</i> must be notified prior to <i>services</i> being rendered.	If Skilled Nursing Facility <i>services</i> are not <i>precertified</i> , benefits for the <i>hospital</i> or <i>qualified treatment facility</i> will be subject to a 50% penalty. The penalty does not apply to the deductible or out-of-pocket maximums.

Covered expenses are payable on a *maximum allowable fee* basis.

This schedule provides a brief overview of Plan benefits and is not a complete description. Refer to the text for a detailed description of *your* Plan benefits.

MEDICAL DEDUCTIBLE AND COINSURANCE INFORMATION	
Deductible:	
Individual	\$ 500
Family	\$1,000
Coinsurance	80% (<i>you</i> pay 20%)
Out-of-Pocket Limit:	
Individual	\$1,500
Family	\$3,000
When the amount of <i>covered expenses</i> paid by <i>you</i> and/or all <i>your</i> covered <i>dependents</i> satisfies the deductible and out-of-pocket limits as shown on the Schedule of Benefits, the Plan will pay 100% of <i>covered expenses</i> for the remainder of the <i>plan year</i> , unless specifically indicated, subject to any <i>plan year</i> maximums of the Plan.	

MEDICAL COVERED EXPENSES	
Inpatient <i>Hospital</i> Semi-private room Organ Transplants Emergency Room Ancillary <i>Services, Emergency Room</i> Physician, Radiology, Pathology, Anesthesia	Payable at 80% after deductible Payable at 80% after deductible Subject to \$50 <i>copayment</i> , than payable at 80% (<i>Copayment</i> is waived if admitted). Payable at 80% after deductible.
Outpatient <i>Hospital</i>	Payable at 80% after deductible.
<i>Free Standing Surgical Facility</i>	Payable at 80% after deductible.
<i>Qualified Practitioner</i>	
Office Visits	Payable at 80% after deductible.
Injections	Payable at 80% after deductible.
Allergy Injections and Vials	Payable at 80% after deductible.
Contraceptive Injections	Payable at 80% after deductible.
X-ray and Lab and Pre-admission testing	Payable at 80% after deductible.
Diagnostic X-ray, Lab and tests	Payable at 80% after deductible.
<i>Qualified Practitioner</i> (Other than Office Visits)	Payable at 80% after deductible.
Second Surgical Opinion	
When required	Payable at 100%.
If not required	Payable at 80% after deductible.
Chiropractic Care	
Exam	Payable at 80% after deductible.
X-ray and Lab	Payable at 80% after deductible.
Therapy	Payable at 80% after deductible.
Manipulations	Payable at 80% after deductible, to a <i>maximum benefit</i> of \$25 per visit.
	<i>Covered expenses</i> for exams, therapy and manipulation aggregate to a <i>maximum benefit</i> of 20 visits per <i>plan year</i>

MEDICAL COVERED EXPENSES	
Routine Care - Adult	
Exam	Payable at 80% after deductible.
Lab and X-ray	Payable at 80% after deductible.
Mammogram, Pap Smear, Immunizations and Prostate Antigen Testing	Payable at 80% after deductible.
Routine Care - Child (Through age 18)	
Exam	Payable at 80% after deductible.
Lab, X-ray and Immunizations	Payable at 80% after deductible.
Autism (ages 2-21)	Payable at 80% after deductible, to a <i>maximum benefit</i> of \$500 per month.
Assisting the Surgeon	20% of primary surgeon's fee, payable at 80% after deductible.
Physician Assistant	20% of primary surgeon's fee, payable at 80% after deductible.
Ambulance Service	Payable at 80% after deductible.
Pregnancy Benefits	
<i>Participant</i> or Spouse	Payable at 80% after deductible.
<i>Dependent</i> daughter	Payable at 80% after deductible.
Newborn Benefits	
Well Newborn	Payable at 80%.
Sick Newborn	Payable at 80% after deductible.
Birthing Centers	Payable at 80% after deductible.
Skilled Nursing Facility	Payable at 80% after deductible, to a maximum of 100 days per <i>plan year</i> . <i>Precertification</i> is required. If <i>precertification</i> is not received, benefits are subject to the penalty described on the Schedule of Benefits.
Home Health Care	Payable at 80% after deductible, to a maximum of 100 days per <i>plan year</i> .
Hospice Care	Payable at 80% after deductible.
<i>Mental Disorder</i> , Chemical Dependence and Alcoholism	
Inpatient	Payable at 80% after deductible, to a maximum of 31 days per <i>Plan year</i> .
Outpatient	Payable at 80% after deductible, to a maximum of 20 days per <i>Plan year</i> .

MEDICAL COVERED EXPENSES	
Speech, Physical, Occupational, Respiratory, Radiation Therapy and Cardiac Rehabilitation	Payable at 80% after deductible, to a <i>maximum benefit</i> of 30 visits per <i>plan year</i> .
Other Covered Expenses	Payable at 80% after deductible.
Temporomandibular Joint Disorder (TMJ)	Payable at 80% after deductible. Prior authorization is required before treatment begins.
Oral Surgeries	Payable at 80% after deductible. Prior authorization is required before treatment begins.

ADDITIONAL CLAIM INFORMATION	
Proof of Loss	Claims must be submitted within 15 months from the date of loss, except if <i>you</i> were legally incapacitated.

UTILIZATION/CASE MANAGEMENT

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

PRECERTIFICATION

Utilization review includes *precertification* and *concurrent review*.

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

If *you* or *your covered dependent* are to receive a *service* which requires *precertification*, *you* or *your qualified practitioner* must contact the *Plan Manager*. Refer to the Schedule of Benefits for time requirements.

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

1. Advise *you* in writing if the proposed treatment plan is *medically necessary*;
2. Advise *you* in writing the number of days the *confinement* is initially *precertified*; and
3. Conduct *concurrent review* as necessary.

If *your qualified practitioner* extends *your confinement* beyond the number of days initially *precertified*, the extension must be *precertified* through *concurrent review*.

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

PENALTY FOR NOT OBTAINING PRECERTIFICATION

If *you* do not obtain *precertification* for *services* being rendered, *your* benefits for the *hospital* or *qualified treatment facility* may be reduced. Refer to the Schedule of Benefits for the applicable penalty.

SECOND SURGICAL OPINION

A second surgical opinion may be required, as provided in the Plan, before the *confinement* will be *precertified*. Benefits for the second surgical opinion, including any *medically necessary* x-ray and laboratory tests performed by the second *qualified practitioner*, are payable as shown on the Schedule of Benefits.

Second Surgical Opinion Continued

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 practitioners* providing the surgical opinions MUST NOT be in the same group practice or clinic. 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*.

DISEASE MANAGEMENT

The Disease Management Programs listed in this section are available to *you* and any eligible *dependents* covered by this Plan. These Disease Management Programs are provided at no cost to *you* or *your qualified practitioner*.

- **Congestive Heart Failure:** This program combines intervention, monitoring and education, which will enable *you* to take a more active role in managing *your* health.
- **Coronary Artery Disease:** This program's objective is to promote good health through education, counseling and support. This program offers educational materials on diet, medication management, exercise, and, if appropriate, smoking cessation.
- **End Stage Renal Disease:** This program is designed to educate *you* and coordinate the multiple facets of *your* care.
- **Neonatal Intensive Care:** This program combines care coordination and parent education to help improve the patient's outcome and reduce stress on the family.
- **Rare Diseases (Cystic Fibrosis, Hemophilia, Multiple Sclerosis, Myasthenia Gravis and Systemic Lupus Erythematosis):** *You* will be educated on the specifics of *your* disease, the possible complications and the treatment options available. The goal is to maintain a high standard of care and help meet *your* medical and psychological needs.
- **Humana Health Advanced Care Partners**
- **Diabetes Program administered by Jewish Hospital** (only available in Louisville, Kentucky)

If *you* have any questions regarding the Disease Management Programs listed in this section, contact the Medical Management team at 1-800-626-2738 and one of the nurses will assist *you*.

PREDETERMINATION OF MEDICAL BENEFITS

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

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

MEDICAL DEDUCTIBLE AND COINSURANCE INFORMATION

Covered expenses are payable, after satisfaction of the deductible, to a *maximum allowable fee* at the coinsurance percentages and up to the maximum benefits shown on the Schedule of Benefits.

DEDUCTIBLE

The deductible applies to each *covered person* each *Plan year*. Only charges which qualify as a *covered expense* may be used to satisfy the deductible. The amount of the deductible is stated on the Schedule of Benefits.

MAXIMUM FAMILY DEDUCTIBLE

The total deductible applied to all *covered persons* in one family in a *plan year* is subject to the maximum shown on the Schedule of Benefits.

COINSURANCE

The term coinsurance means the shared financial responsibility for *covered expenses* between the *covered person* and the self-insured plan.

Covered expenses are payable at the applicable percentage rate shown on the Schedule of Benefits after the deductible is satisfied each *plan year*.

OUT-OF-POCKET LIMIT

When the amount of *covered expenses* paid by *you* and/or all *your covered dependents* satisfy the deductible and out-of-pocket limits as shown on the Schedule of Benefits, the Plan will pay 100% of *covered expenses* for the remainder of the *plan year*, unless specifically indicated, subject to any *plan year* maximums of the Plan.

Covered expenses are subject to any *plan year* maximums of the Plan.

MEDICAL COVERED EXPENSES

INPATIENT HOSPITAL

Covered expenses are payable as shown on the Schedule of Benefits and include charges made by a:

1. *Hospital* for daily semi-private, ward, intensive care or coronary care room and board charges for each day of *confinement*. The maximum amount payable is shown on the Schedule of Benefits. 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;
2. *Hospital* for *services* furnished for your treatment during *confinement*.

OUTPATIENT HOSPITAL

Covered expenses are payable as shown on the Schedule of Benefits and include charges made by a *hospital* for:

1. Treatment of a *bodily injury*, including the emergency room charge if rendered within 48 hours of an accident;
2. Treatment of a *sickness* following an *emergency*, including the emergency room charge;
3. *Preadmission testing*;
4. A surgical procedure;
5. Regularly scheduled treatment such as chemotherapy, inhalation therapy, radiation therapy as ordered by *your* attending physician.

FREE-STANDING SURGICAL FACILITY

Charges made by a *free-standing surgical facility*, for surgical procedures performed and for *services* rendered in the facility are payable as shown on the Schedule of Benefits.

QUALIFIED PRACTITIONER

Covered expenses are payable as shown on the Schedule of Benefits and include charges made by a *qualified practitioner* when incurred for:

1. Office, home, *emergency* room physician or inpatient *hospital* visits;
2. Diagnostic x-ray or laboratory tests;
3. Professional *services* of a radiologist or pathologist for diagnostic x-ray examination or laboratory tests, including x-ray, radon, radium, and radioactive isotope therapy;
4. Other covered medical *services* received from or at the direction of a *qualified practitioner*;
5. Administration of anesthesia;

Qualified Practitioner Continued

6. A surgical procedure, including pre-operative and post-operative care.

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

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

No benefits will be payable for incidental procedures.

7. Assisting the surgeon;
8. Physician assistant;
9. Charges made by a *qualified practitioner* for *services* in performing certain oral surgical operations due to *bodily injury* or *sickness* are covered as follows:
 - a. Excision of partially or completely unerupted impacted teeth;
 - b. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological examination;
 - c. Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
 - d. Reduction of fractures and dislocations of the jaw;
 - e. External incision and drainage of cellulitis.

CHIROPRACTIC CARE

Charges are payable as shown on the Schedule of Benefits. Maintenance care is not covered.

ROUTINE CARE - ADULT

The following expenses are payable for *you* or *your* covered *dependent*, up to the amount shown on the Schedule of Benefits, subject to all terms and provisions of the Plan, except the exclusion for *services* which are not *medically necessary*, if *you* are not confined in a *hospital* or *qualified treatment facility* and if such expenses are not incurred for diagnosis of a specific *bodily injury* or *sickness*.

Benefits include:

1. Routine exams and annual checkups;
2. Immunizations, including the flu shot;
3. Pap smears;

Routine Care-Adult Continued

4. Routine Mammograms: ages 35-39 - one baseline;
ages 40-49 - one every two years;
ages 50 and over - one every year;
 - may be performed prior to age 35 if medically necessary;
 - mammograms performed for diagnostic or medical reasons are not considered routine, and are subject to the deductible.
5. Routine x-ray and laboratory tests;
6. Prostate antigen testing: age 50 and over - one screening per year (may be performed prior to age 50 if medically necessary).

No benefits are payable under this benefit for:

1. Any dental examinations;
2. Hearing examinations;
3. Medical examination for *bodily injury* or *sickness*;
4. Medical examination caused by or resulting from pregnancy.

ROUTINE CARE - CHILD

(Through age 18)

The following expenses are payable for *you* or *your* covered *dependent*, up to the amount shown on the Schedule of Benefits, subject to all terms and provisions of the Plan, except the exclusion for *services* which are not *medically necessary*, if *you* are not confined in a *hospital* or *qualified treatment facility* and if such expenses are not incurred for diagnosis of a specific *bodily injury* or *sickness*.

Benefits include:

1. Routine exams and annual checkups;
2. Immunizations;
3. Routine x-ray and laboratory tests;

No benefits are payable under this benefit for:

1. Any dental examinations;
2. Hearing examinations;
3. Medical examination for *bodily injury* or *sickness*;

Medical examination caused by or resulting from pregnancy.

AUTISM BENEFIT

Rehabilitative Services-Speech, Occupational, and Physical Therapy

Benefits are provided for rehabilitative services (speech, occupational, and physical therapy) provided under the order and direction of the Covered Person's Physician or authorized by the *Plan Manager*. These *services* will be subject to a limit of 30 visits per Plan Year.

Therapeutic Services-Mental Health

Benefits are provided for psychiatric, psychological and behavioral management *services* rendered as an outpatient by the Plan's Psychiatric Designee. Services must be authorized in advance by the Plan and its Psychiatric Designee.

Respite Services

Benefits are provided for Respite Services performed and rendered as an outpatient by an approved health care program, approved Home Health Agency, or other Participating Provider. *Services* must be directed and monitored by a Participating Physician and authorized in advance by the *Plan Manager*.

Limitations

Rehabilitative, Therapeutic, and Respite benefits are limited to children from 2 years through 21 years of age with a diagnosis of Autism established by a Participating Provider consistent with the criteria established in Kentucky, Senate Bill 63 and who are enrolled in this benefits structure at the time services are provided. All benefits are limited to \$500.00 per Child per month. Benefits not used during the month will not be carried over into future months.

All contractual limitations, exclusions, and Co-Payments will be applied as outlined in the Plan.

AMBULANCE SERVICE

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

HUMANA BEGINNINGS

The "Humana Beginnings Program" is a service provided to *participants* and their eligible *dependents* of this Plan by the *Plan Manager*. This program is designed as a special service that helps mothers receive appropriate prenatal care.

- First, call the *precertification* phone number shown on the back of *your* ID card as soon as *your* pregnancy has been confirmed by a *qualified practitioner*. When *you* call, one of the nurses will ask *you* questions such as: *your* estimated date of delivery, if *you* had any problems with previous pregnancies, and *your* ongoing medical conditions, just to name a few. These questions are held in confidence between *you* and the nurse to whom *you* are speaking. Answers to these questions, along with *your* approval, will help the nurse and *your* doctor decide whether *you* need special care during *your* pregnancy.

- If *you* and/or *your* baby need special care before or after delivery, a nurse is available to assist in managing *your* care. The nurse will obtain the necessary consents from *you* to manage *your* care. The nurse case manager will then monitor the treatment plan and facilitate with *your* health care professional to ensure *you* are receiving the best care while getting the most out of *your* health insurance benefits.
- If *your* health care professional admits *you* to a *hospital* during *your* pregnancy, please follow the *precertification* requirements defined in *your* benefit booklet for *emergency* and planned admissions.
- When *you* deliver *your* baby, *you* may not feel up to calling the *Plan Manager* (or as indicated on *your* ID card). Remind *your* partner, relative or health care professional to call for *you*.
- If *you* do not contact the *Plan Manager* during *your* pregnancy, benefits for the *qualified practitioner's* delivery charges may be reduced. Refer to the Schedule of Benefits for the applicable penalty.

If *you* have any questions, call the *Plan Manager* (or as indicated on *your* ID card) and one of our nurses will help *you*.

PREGNANCY BENEFITS

Pregnancy is a *covered expense* for any *covered person* payable as shown on the Schedule of Benefits.

Complications of pregnancy are payable as any other covered *sickness* at the point the complication sets in for any *covered person*.

Pregnancy benefits are subject to all terms and provisions of the Plan.

In accordance with federal law, benefits for the inpatient *hospital* stay, in connection with childbirth for the mother or newborn child, may not be restricted to less than 48 hours following a normal 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. In any case, the Plan may not, under federal law, require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours, or 96 hours as applicable.

NEWBORN BENEFITS

Benefits for newborns are subject to the Eligibility and Effective Date of Coverage section of this booklet, as well as all terms and provisions of the Plan.

WELL-NEWBORN

Covered expenses incurred during a well-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*.

SICK-NEWBORN

Covered expenses for a sick-newborn are *expenses incurred* for the treatment of a *bodily injury* or *sickness*.

BIRTHING CENTERS

A birthing center is a free standing facility, licensed by the state, which provides prenatal care, delivery and immediate postpartum care, and care of the newborn child.

Expense incurred within 24 hours after *confinement* in a birthing center for *services* and supplies furnished for prenatal care and delivery of child(ren) are payable as shown on the Schedule of Benefits.

SKILLED NURSING FACILITY

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

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

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 disorders*, chemical dependence, or alcoholism.

BENEFITS PAYABLE

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

HOME HEALTH CARE

Expense incurred for home health care as described below is payable as shown on the Schedule of Benefits.

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 the 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 and respiratory therapy and home health aide *services*; and
3. Medical supplies and *durable medical equipment*, laboratory *services* and nutritional counseling, if such *services* and supplies would have been covered if *you* were *hospital* confined.

LIMITATIONS ON HOME HEALTH CARE BENEFITS

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; or
3. Charges for supervision of home health care providers.

HOSPICE CARE

Hospice *services* must be furnished in a hospice facility or in *your* home. A *qualified practitioner* must certify *you* are terminally ill with a life expectancy of six months or less.

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

Covered expenses are payable as shown on the Schedule of Benefits for the following hospice *services*:

1. Room and board and other *services* and supplies;
2. Part-time nursing care by or supervised by a R.N. 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; and
8. Medical supplies prescribed by a *qualified practitioner*; and
9. Bereavement counseling *services* by a *qualified practitioner* for *your* immediate family to a *maximum benefit* of 12 sessions during a 12 month period, payable to a *maximum benefit* of \$50 per session.

LIMITATIONS ON HOSPICE CARE BENEFITS

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.

ORGAN TRANSPLANT BENEFIT

The plan will pay benefits only for services, care, and treatment received for or in connection with the approved transplantation of the following human organs:

1. Heart;
2. Lung(s);
3. Heart/Lung(s);
4. Liver;
5. Pancreas;
6. Kidney;
7. Kidney/Pancreas;
8. Bone marrow procedures for transplants where are both accepted within the appropriate oncological specialty and not considered experimental.

Corneal transplants, which are tissues rather than organs, do not require prior approval.

As used in this document, the term “bone marrow transplant” means human blood precursor cells which are administered to a patient following ablative or myelosuppressive therapy. Such cells may be derived from bone marrow, circulating blood, placental blood, umbilical cord blood or a combination of bone marrow and blood obtained from the patient in an autologous transplant or from a matched related or unrelated donor. If chemotherapy is an integral part of the treatment involving bone marrow transplantation, the term “bone marrow transplant” includes the harvesting, the transplantation and the chemotherapy components.

For a transplant procedure to be considered approved for this transplant benefit, prior approval from the *plan manager* is required in advance of the procedure. The *plan manager* must be notified by either the patient or his/her physician in advance of the initial evaluation for the procedure to determine if the transplant services will be covered. For approval of the transplant itself, the *plan manager* must be given the opportunity to evaluate the clinical results of the evaluation. If approval is not given, benefits will not be provided for any part of the transplant procedure as defined above. Additional transplants will be added to this Organ Transplant Benefit section if they are determined by the American Medical Association DATA panel to no longer be experimental or investigational.

COVERED EXPENSES FOR TRANSPLANT PROCEDURES

For approved transplant procedures, and all related complications, the plan will pay benefits only for the following covered expenses:

1. Hospital expenses and physician expenses will be paid under the hospital benefit and physician’s benefit in the plan in accordance with the same terms and conditions as for care and treatment of any other covered injury or sickness.
2. Transportation costs for the covered *participant* to and from the approved facility where the transplant facility is more than 100 miles from the covered *participant’s* home.
3. Direct, non-medical costs for one member of the covered *participant’s* immediate family (two members if the patient is under age 18 years) for:
 - a. Transportation to and from the approved facility where the transplant is performed, but no more than one round trip per person per transplant, and
 - b. Temporary lodging at a prearranged location during the covered *participant’s* confinement in the approved facility, not to exceed \$75 per day.

Direct non-medical costs are only payable if the covered *participant* lives more than 100 miles from the approved transplant facility. There is a \$5000 maximum for these direct, non-medical expenses.

4. When physician’s services are required for kidney, cornea or bone marrow transplants from a living donor to a transplant recipient requiring surgical removal of a donated part, the following will determine the benefits to be provided, but only when the physician customarily bills the recipient for such services.
 - a. When the transplant recipient and donor are both covered *participants* under this plan, benefits will be provided for both under each individual’s available coverage.

- b. When only the transplant recipient is eligible under this plan, benefits will be provided for both to the extent that benefits to the donor are not provided under any other coverage. In such instances, donor utilization of benefits will be charged against the recipient's coverage.
- c. When the transplant recipient is not eligible under this plan, and the donor is, the donor will receive his or her plan benefits for surgical and medical care necessary to the extent such benefits are not provided by any coverage available to the recipient for the organ or tissue transplant procedure. Benefits will not be provided to any non-eligible transplant recipient.

EXCLUSIONS FOR TRANSPLANT PROCEDURES

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

1. The organ or diagnosis involved is not listed in this subsection of the plan. Transplants that are not covered include, but are not limited to, islet cells, bowel(s), stomach, thymus, and pituitary. Bone marrow and liver transplants are also excluded except as provided in this subsection of the plan.
2. The *plan manager* is not contacted for authorization prior to referral for transplant evaluation of the procedure, or does not approve coverage for the procedure, based on their established criteria.
3. The transplant procedure is performed in a facility that has not been approved by the *plan manager*.
4. Expenses are eligible to be paid under any private or public research fund, government program except Medicaid, or other 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.
6. The expense relates to the donation or acquisition of an organ for a recipient who is not covered by the plan.
7. A denied transplant is performed; this includes the transplant procedure, follow up care, immuno-suppressive drugs, and complications of such transplant.
8. Artificial heart devices used as a bridge to transplant unless they have FDA approval.
9. Drugs used in connection with diagnosis or treatment leading to a transplant when such drugs have not received FDA approval for such use, unless the drug is prescribed for treatment of cancer and that drug is recognized for treatment of that indication in a standard reference compendium or recommended in the medical literature.
10. Benefits are not provided for services and supplies related to a covered procedure received during the first nine (9) months after the effective date. In determining whether a pre-existing condition existed, the time the *participant* was covered under any previous health plan will be credited if the coverage or combination of coverages totals nine (9) months and the previous coverage was continuous to a date not more than 63 days prior to the *participant's* effective date.

MENTAL DISORDER, CHEMICAL DEPENDENCE OR ALCOHOLISM BENEFIT

Expense incurred by you during a plan of treatment for *mental disorder*, chemical dependence or alcoholism is payable for:

1. Charges made by a *qualified practitioner*;
2. Charges made by a *hospital*;
3. Charges made by a *qualified treatment facility*.

INPATIENT BENEFITS

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

Covered expenses for inpatient treatment do not aggregate toward the coinsurance and out-of-pocket limits described on the Schedule of Benefits.

OUTPATIENT BENEFITS

Covered expenses for outpatient treatment received while not confined in a *hospital* or *qualified treatment facility* are payable as shown below:

Covered expenses for outpatient treatment do not aggregate toward the coinsurance and out-of-pocket limits described on the Schedule of Benefits.

LIMITATIONS ON MENTAL DISORDER, CHEMICAL DEPENDENCE OR ALCOHOLISM BENEFITS

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 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. Oxygen and rental of equipment for its administration;
3. Initial prosthetic devices or supplies, including but not limited to, limbs, and eyes. Coverage will be provided for prosthetic devices necessary to restore minimal basic function. Replacement is a *covered expense* if due to pathological changes. *Covered expense* includes repair of the prosthetic device if not covered by the manufacturer;
4. Casts, trusses, crutches, splints except for dental splints, and braces except for orthodontic braces;
5. Supplies, up to a 30-day supply, when prescribed by *your* attending physician;
6. Initial contact lenses or eyeglasses following cataract *surgery*;
7. The rental, up to but not to exceed the purchase price, of a wheelchair, hospital bed, ventilator, hospital type equipment or other *durable medical equipment (DME)*. The 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. Repair, maintenance, or duplicate *DME* rental is not considered a *covered expense*;
8. Chiropractic care for treatment of a *bodily injury* or *sickness*. *Maintenance care* is not covered;
9. Extraction of a *sound natural tooth* lost due to a *dental injury*. The *dental injury* and replacement must occur while *you* are covered under the Plan. *Services* must begin within 12 months and be completed within 12 months after the date of the *dental injury*. Benefits will be paid only for *expense incurred* for the least expensive *service* that will, in the *Plan Manager's* opinion, produce a professionally adequate result;
10. Installation and use of an insulin infusion pump, diabetic self-management education programs and other equipment or supplies in the treatment of diabetes.
11. Surgical or non-surgical treatment including but not limited to, appliances and therapy, 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; surgical or non-surgical treatment of the facial muscles used in expression and mastication functions, for symptoms including but not limited to, headaches. Prior authorization is required. These expenses do not include charges for orthodontic *services*;
12. Reconstructive *surgery* due to *bodily injury*, infection or other disease of the involved part which occurs while *you* are covered under this Plan, or congenital disease or anomaly of a covered *dependent* child which resulted in a functional defect;

Other Covered Expenses Continued

13. 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;
14. Transplants are subject to all provisions of the Plan applicable at the time the expense is incurred, including but not limited to, the limitations and exclusions and the definitions found in this Plan and the following additional Plan provisions:
 - a. when both the recipient and the donor are covered by the Plan, each is entitled to the benefits of the Plan;
 - b. when only the recipient is covered by the Plan, the recipient is entitled to the benefits of the Plan. The donor's benefits are limited to only those eligible charges for services to donate the tissue, joint or human organ and not provided or available to the donor from any other source. Another source includes, but is not limited to, any insurance coverage, medical plan, or any government program. Benefits provided to the donor are charged against the recipient's coverage under the Plan;
 - c. when only the donor is covered by the Plan, the donor is entitled to the benefits of the Plan. The benefits are limited to only those not provided or available to the donor from any other source. Another source includes, but is not limited to, any insurance coverage or any governmental program available to the recipient. No benefits are provided to the non-covered transplant recipient;
 - d. if any organ tissue is sold rather than donated to the covered recipient, no benefits are payable for the purchase price of such organ or tissue; however, other costs related to the evaluation and procurement are covered for the recipient up to the benefit limitation of the Plan.
15. Speech, occupational, physical and respiratory therapy;
16. Chemotherapy and radiation therapy;
17. Cardiac rehabilitation, limited to phases I and II;
18. *Services* for morbid obesity;

The following *services* are considered other *covered expenses* and are payable as shown on the Schedule of Benefits, subject to all terms and provisions of the Plan, except the exclusion for *services* which are not *medically necessary*: elective sterilizations; birth control devices, injections, or implant systems and their removal.

LIMITATIONS AND EXCLUSIONS

The 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 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; or
 - f. Furnished by or payable under any plan or law through any government or any political subdivision (this does not include *Medicare* or *Medicaid*);
 - g. Furnished for a military service connected *sickness* or *bodily injury* by or under an agreement with a department or agency of the United States Government, including the Department of Veterans Affairs;
 - h. Performed in association with a *service* that is not covered under this Plan;
 - i. Performed as a result of a complication arising from a *service* that is not covered under this Plan;
2. Routine eye exams, *services* to correct eye refractive disorders, eyeglass frames and lenses or contact lenses, the fitting or repair of eyeglass frames and lenses or contact lenses, unless specifically indicated in Other Covered Expenses #7;
3. Routine hearing exams, hearing aids, the fitting, or repair of hearing aids;
4. Exams and related *services*, for occupation, employment, school, travel, purchase of insurance or premarital tests or examinations;
5. Elective abortions, unless the pregnancy is a life-threatening physical condition of the covered female person. In the instance of a life-threatening physical condition, Abortifacients would be a *covered expense*.
6. *Services* related to gender change;
7. *Services* for a reversal of sterilization;
8. Treatment of any *bodily injury* or *sickness* that is sustained by an *participant* or a covered *dependent* that arises out of, or as the result of, any work for wage or profit when coverage under any Workers' Compensation Act or similar law is required for the *participant* or covered *dependent*;

Limitations and Exclusions Continued

9. *Services for cosmetic surgery* and/or complications arising from cosmetic services;
10. Dental *services* or appliances for the treatment of the teeth, gums, jaws or alveolar processes, including but not limited to, implants and related procedures, and orthodontic procedures, unless specifically provided under this Plan;
11. Any loss caused by or contributed to:
 - a. War or any act of war, whether declared or not, or
 - b. Any act of armed conflict, or any conflict involving armed forces of any authority;
12. The treatment of *mental disorders*, chemical dependence or alcoholism unless specifically provided under this Plan;
13. Any device which does not have the United States Food and Drug Administration formal market approval through a New Drug Application, Premarket Approval, 510K, or PLA;
14. Any *service* which is *experimental, investigational or for research purposes*;
15. *Custodial care and maintenance care*;
16. *Services* provided by a person who ordinarily resides in *your* home or who is a *family member*;
17. Charges in excess of the *maximum allowable fee* for the *service*;
18. Any *expense incurred* prior to *your* effective date under the Plan or after the date *your* coverage under the Plan terminates, except as specifically described in this Plan;
19. Any expense due to commission or attempt to commit a civil or criminal battery or felony;
20. *Services not medically necessary* for diagnosis and treatment of a *bodily injury or sickness*;
21. Private duty nursing;
22. *Expenses incurred* for which *you* are entitled to receive benefits under *your* previous dental or medical plan;
23. All fertility testing or *services* (other than diagnostic testing or services), including any artificial means to achieve pregnancy or ovulation, such as 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;

Limitations and Exclusions Continued

24. 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;
25. 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*;
26. Prescription drugs for which coverage is available under the Prescription Drug Benefit;
27. *Services* related to the treatment and/or diagnosis of sexual dysfunction/impotence;
28. Dental Osteotomies.

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

OPEN ENROLLMENT

Once each year *you* will have a choice of enrolling in this Plan or another offered by the University of Kentucky. *You* will be notified in advance when the open enrollment period is to begin and how long it will last. There will be no medical underwriting or any pre-existing limitation for those who transfer from one plan to the other.

ELIGIBILITY

In order to be eligible to enroll for coverage under the Plan, *you* must be:

1. A regular full-time employee;
2. A regular half-time employee;
3. A regular part-time employee, with an assignment of .20 Full Time Equivalent (FTE) or more;
4. A temporary part, half- or full-time employee with an assignment of at least .20 FTE, and with sufficient earnings to make the necessary premium payments;
5. Other eligible *participants* as defined by the University of Kentucky Medical Benefits Plan Document; or
6. An eligible Retiree, defined as a retiree who is:
 - a. Retired in accordance with University of Kentucky retirement regulations; and
 - b. Has a minimum of five (5) years of regular full-time employment or its equivalent at the time of retirement; and
 - c. Enrolled in a University of Kentucky health plan at the time of retirement.

Early retirees may retain coverage on the same basis as an employee until he or she becomes eligible for Medicare.

On-Call employees are NOT eligible for coverage under the Plan.

EFFECTIVE DATE OF COVERAGE

If *you* are eligible for coverage, *you* may elect to be covered through the enrollment process. The date *your* coverage begins depending on the date on which *you* enroll. Subject to making any required contribution, *your* coverage will start as described in the paragraphs which follow:

1. If *you* are eligible for coverage on the effective date of the Plan, *your* coverage will start on the effective date of the Plan if *you* enrolled for coverage when *you* were first eligible for it.
2. If *you* become eligible after the effective date of the Plan and *you* enroll within 30 days after the date *you* first become eligible, *your* coverage will start the first of the month following the date *you* were hired.
3. If *you* do not enroll within 30 days after the date *you* first become eligible to do so, then *you* will not be permitted to enroll in the plan until the next open enrollment period, unless *you* have a qualifying family status change.

DEPENDENT ELIGIBILITY

You are eligible for Dependent coverage only if *you* are a covered *participant*. If *you* have one or more *dependents* as of the date *you* become a covered *participant*, *you* are eligible for *dependent* coverage on that date. If *you* do not have any *dependents* on the date *you* become a covered *participant*, *you* do not qualify for *dependent* coverage. *You* will become eligible for it on the date *you* acquire a *dependent*.

If *your dependent* is eligible for coverage, he or she may not be enrolled for coverage as both a covered *participant* and a *dependent*. In addition, no person can be enrolled as a *dependent* of more than one covered *participant*. An adopted child is eligible for *dependent* coverage upon the date of placement in *your* home.

EFFECTIVE DATE OF DEPENDENT COVERAGE

If eligible, *you* may elect to cover *your dependents* through the enrollment process. Subject to making any required contribution, *dependent* coverage will start as described in the paragraphs which follow:

1. If *you* are eligible for coverage on the effective date of the plan, *dependent* coverage will start on the effective date of the plan, but only if *you* enrolled for *dependent* coverage when *you* were first eligible for it.
2. If *you* become eligible after the effective date of the plan and *you* enroll within 30 days after the date *you* first become eligible, *dependent* coverage will start on the first of the month following the date of hire.
3. If *you* do not enroll within 30 days after the date *you* first become eligible to do so, then *you* will not be permitted to enroll in the plan until the next open enrollment period, unless *you* have a qualifying family status change.

CREDITABLE COVERAGE

Once *you* or *your dependents* obtain health plan coverage, *you* are entitled to use evidence of that coverage to reduce or eliminate any pre-existing condition limitation period that might otherwise be imposed when *you* become covered under a subsequent health plan. Evidence may include a certificate of prior *creditable coverage*. The length of any pre-existing condition limitation period under the subsequent health plan must be reduced by the number of days of *creditable coverage*.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

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

RETIREE COVERAGE

If *you* are a retiree who meets the University of Kentucky's retiree qualifications, *you* may continue coverage under the Plan with retiree benefits for *you* and any of *your* eligible *dependents*.

SPECIAL ENROLLMENT

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

1. Loss of eligibility for the coverage due to any of the following:
 - a. Legal separation;
 - b. Divorce;
 - c. Death;
 - d. Termination of employment;
 - e. Reduction in the number of hours of employment;
 - f. Any loss of eligibility after a period that is measured by reference to any of the foregoing.

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

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

If *you* are a covered *participant*, *you* have the opportunity to enroll any newly acquired *dependents* when due to any of the following family status changes:

1. Marriage;
2. Birth; or
3. Adoption or placement for adoption.

You may elect coverage under this Plan provided enrollment is within 30 from the qualifying event. *You* MUST provide proof that the qualifying event has occurred due to one of the reasons listed before coverage under this Plan will be effective. Coverage under this Plan will be effective the date immediately following the date of the qualifying event, unless otherwise specified in this section.

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

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

If *you* become eligible for coverage under this Plan through the special enrollment provision, benefits under the Plan will not be subject to the *pre-existing condition* with the exception of Transplant Services. If *you* apply more than 30 days after a qualifying event, *you* will not be eligible for coverage under this Plan until the next annual open enrollment period.

Please see *your employer* for more details.

TERMINATION OF COVERAGE

Coverage terminates on the earliest of the following:

1. The date the Plan terminates;
2. The end of the period for which any required contribution was due and not paid;
3. The end of the calendar month *you* enter full-time military, naval or air service, except coverage may continue during an approved military leave of absence as indicated in the Special Provisions For Not Being in Active Status provision;
4. The end of the calendar month *you* fail to be in an eligible class of persons according to the eligibility requirements of the *employer*;
5. For all *employees*, the end of the calendar month following the month in which *you* terminate employment with *your employer*, provided you have made the required premium contribution;
6. For any benefit, the date the benefit is removed from the Plan;
7. For *your dependents*, the date *your* coverage terminates;
8. For a *dependent*, the end of the calendar month the *dependent* enters full-time military, naval or air service;
9. For a *dependent*, the end of the calendar month such *covered person* no longer meets the definition of *dependent*.

IF *YOU* OR ANY OF *YOUR COVERED DEPENDENTS* NO LONGER MEET THE ELIGIBILITY REQUIREMENTS, *YOU* ARE RESPONSIBLE FOR NOTIFYING THE *PLAN ADMINISTRATOR* OF THE CHANGE IN STATUS. COVERAGE WILL NOT CONTINUE BEYOND THE LAST DATE OF ELIGIBILITY EVEN IF NOTICE HAS NOT BEEN GIVEN TO THE *PLAN ADMINISTRATOR* OR THE *PLAN MANAGER*.

IMPORTANT NOTICE FOR EMPLOYEES AND SPOUSES AGE 65 AND OVER

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

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

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

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

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

You have the option to reject plan coverage offered by *your* employer, as does any eligible *employee*. If *you* reject coverage under *your* employer's Plan, coverage is terminated and *your* employer is not permitted to offer *you* coverage that supplements *Medicare* covered services.

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

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

CONTINUATION OF MEDICAL BENEFITS

THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1986 (COBRA)

CONTINUATION OF BENEFITS

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

ELIGIBILITY

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

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

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

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

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

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

- The death of the *employee* parent;
- The termination of the *employee* parent's employment (for reasons other than gross misconduct) or reduction in the *employee* parent's hours of employment with the *employer*;
- The *employee* parent's divorce or legal separation;
- Ceasing to be a "*dependent* child" under the Plan;
- The *employee* parent becomes entitled to *Medicare* benefits; or
- Termination of the retiree parent's coverage when the former *employer* discontinues retiree coverage within one year before or one year after filing for Chapter 11 bankruptcy.

COBRA Continued

LOSS OF COVERAGE

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

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

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

NOTICES AND ELECTION

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

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

For termination of employment, reduction in work hours, the death of the *employee*, the *employee* becoming covered by *Medicare* or loss of retiree benefits due to bankruptcy, it is the Plan Administrator's responsibility to notify the qualified beneficiary of the right to elect continuation coverage.

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

COBRA Continued

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

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

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

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

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

MAXIMUM COVERAGE PERIOD

Coverage may continue up to:

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

COBRA Continued

DISABILITY

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

SECOND QUALIFYING EVENT

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

TERMINATION BEFORE THE END OF MAXIMUM COVERAGE PERIOD

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

- The *employer* no longer provides group health coverage to any of its *employees*;
- The premium for continuation is not paid timely;
- The individual on continuation becomes covered under another group health plan (as an *employee* or otherwise); however, if the new plan coverage contains any exclusion or limitation with respect to any *pre-existing condition*, then continuation coverage will end for this reason only after the exclusion or limitation no longer applies or prior *creditable coverage* satisfies the exclusion or limitation;

NOTE: the federal Health Insurance Portability and Accountability Act of 1996 requires portability of health care coverage effective for plan years beginning after June 30, 1997, an exclusion or limitation under the other group health plan may not apply at all to the qualified beneficiary, depending on the length of his or her prior *creditable coverage*. Portability means once *you* obtain health insurance, *you* will be able to use evidence of that insurance to reduce or eliminate any pre-existing medical condition limitation period (under certain circumstances) when *you* move from one health plan to another.

- The individual on continuation becomes entitled to *Medicare* benefits;

COBRA Continued

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

TYPE OF COVERAGE; PREMIUM PAYMENT

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

The initial premium payment for continuation coverage is due by the 45th day after coverage is elected.

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

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

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

OTHER INFORMATION

Additional information regarding rights and obligations under the Plan and under federal law may be obtained by contacting the Plan Administrator or the *Plan Manager*.

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

PLAN CONTACT INFORMATION

University of Kentucky
115 Scovell Hall
Lexington, KY 40506-0064
Louisville, KY 40201
Telephone: (859) 257- 9555 ext. 1

Humana Insurance Company
Billing/Enrollment Department
101 E. Main Street
Louisville, KY 40201
Toll Free: 1-800-872-7207

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

CONTINUATION OF BENEFITS

Effective October 13, 1994 federal law requires that health plans must offer to continue coverage for *employees* who are absent due to service in the uniformed services and/or their *dependents*. Coverage may continue for up to 18 or 24 months after the date the *employee* is first absent due to uniformed service.

ELIGIBILITY

An *employee* is eligible for continuation under USERRA if absent from employment because of voluntary or involuntary performance of duty in the Armed Forces, Army National Guard, Air National Guard, the commissioned corps of the Public Health Service, or any other category of persons designated by the President in time of war or national emergency. Duty includes absence for active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, and for the purpose of an examination to determine fitness for duty.

An *employee's dependents* who have coverage under the Plan immediately prior to the date of the *employee's* covered absence are eligible to elect continuation under USERRA.

PREMIUM PAYMENT

If continuation of Plan coverage is elected under USERRA, the *employee* or *dependent* is responsible for payment of the applicable cost of coverage. If the *employee* is absent for not longer than 31 days, the cost will be the amount the *employee* would otherwise pay for coverage. For absences exceeding 31 days, the cost may be up to 102% of the cost of coverage under the Plan. This includes the *employee's* share and any portion previously paid by the *employer*.

DURATION OF COVERAGE

Elected continuation coverage under USERRA will continue until the earlier of:

- 18 months beginning the first day of absence from employment due to service in the uniformed services for elections made prior to 12/10/04; or
- 24 months beginning the first day of absence from employment due to service in the uniformed services for elections beginning on or after 12/10/04; or
- The day after the *employee* fails to apply for or return to employment as required by USERRA, after completion of a period of service.

Under federal law, the period of coverage available under USERRA shall run concurrently with the COBRA period available to an *employee* and/or eligible *dependents*.

OTHER INFORMATION

Employees should contact their *employer* with any questions regarding coverage normally available during a military leave of absence or continuation coverage and notify the *employer* of any changes in marital status, or a change of address.

CLAIM INFORMATION

NOTICE OF CLAIM

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

PROOF OF LOSS

Claims must be submitted within 15 months from the date of loss, except if *you* were legally incapacitated.

HOW TO FILE A MEDICAL CLAIM

You will receive identification (ID) card which will contain information regarding *your* coverage. Present *your* ID card to the *hospital*, clinic, or physician's office for *services*. The bills can be submitted on the provider's own claim forms and sent directly to the *Plan Manager*. No special claim forms are required. *You* can mail the bills to the *Plan Manager* if the facility or physician providing *services* does not forward them. Pre-addressed claim envelopes are available for *your* use from *your employer*.

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

Be sure each bill shows the group number and plan member number (the *participant's* Social Security number) found on *your* ID card. The *participant's* name and the name of the person who received the *services* or treatment should also be included.

MISCELLANEOUS MEDICAL CHARGES

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

PAYMENT OF CLAIMS

The *Plan Manager* will make direct payment to the *hospital*, clinic, physician's office, unless the *Plan Manager* 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 *participant*" and send it directly to the *Plan Manager*. *You* will receive a written explanation of the benefit determination. The *Plan Manager* reserves the right to request any information required to determine benefits or process a claim. *You* or the provider of *services* will be contacted if additional information is needed to process *your* claim.

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

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.

Claim Information Continued

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

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

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

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

COORDINATION OF BENEFITS

BENEFITS SUBJECT TO THIS PROVISION

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

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

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

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

EFFECT ON BENEFITS

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

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

ORDER OF BENEFIT DETERMINATION

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

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

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

Coordination of Benefits Continued

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

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

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

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

COORDINATION OF BENEFITS WITH MEDICARE

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

RIGHT OF RECOVERY

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

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

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

REIMBURSEMENT/SUBROGATION

Subrogation applies when another party (person or organization) is, or may be, considered responsible for causing *bodily injury* or for payment of benefits due to a *covered person's bodily injury* or *sickness* for which benefits under the Plan have been provided or paid. To the extent of such benefits, the Plan is subrogated to all rights and claims for recovery the *covered person* has against any party (including a health care carrier) responsible for the *bodily injury* or for payment to the *covered person* on account of the *bodily injury*.

Also, the Plan has a right of reimbursement. If payment (by settlement, judgment or any other manner) is made, or may be made, in the future by, or on behalf of, a responsible party to the *covered person*, expenses arising from the *covered person's bodily injury* or *sickness* are not covered by the Plan.

However, if a claim is filed for which benefits would be payable in the absence of a responsible party as described above, benefits will be paid subject to the following conditions:

1. The Plan will automatically have a lien to the extent of benefits advanced upon any recovery, by settlement, judgment or otherwise that *you* receive from the responsible party, or any person or organization making payment on behalf of the responsible party, including first party, undercovered and uncovered motorist coverage. The lien will be in the amount of benefits provided or paid by the Plan for the treatment of the condition for which the third party is responsible.
2. *You* agree to notify the Plan, in writing, within 60 days of your claim against the responsible party and to take such action, furnish such information, cooperate generally, and execute any documents as the Plan may be required to facilitate enforcement of the Plan's rights.

Exclusively at the Plan's option and choice, and without any waiver of any other rights of the Plan, in the event of prejudice, non-cooperation or breach of this Plan, payments may be withheld, deducted, or retracted to or on behalf of the *covered person*.

AGREEMENT AND COOPERATION REQUIRED

Covered persons under the Plan must agree to the following obligations in return for the payment of *covered expenses* by the Plan in accordance with its provisions.

The *covered person* shall cooperate by providing information and executing any documents to preserve the Plan's right and shall have the affirmative obligation of notifying the Plan that claims are being made against responsible parties to recover for injuries for which the Plan has paid. If the *covered person* enters into litigation or settlement negotiations regarding the obligations of the other party, the *covered person* must not prejudice, in any way, rights to recover an amount equal to any benefits that have provided or paid for the *bodily injury* or *sickness*. Failure of the *covered person* to provide such notice or cooperation, or any action by the *covered person* resulting in prejudice to the 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, the *Plan Manager* may deduct from any pending or subsequent claim made under the Plan any amounts the *covered person* owes the Plan until such time as cooperation is provided and the prejudice ceases.

Reimbursement/Subrogation Continued

The Plan's right of reimbursement and the Plan's subrogation rights shall be to the fullest extent allowed by law and the provisions of this Plan shall control in the absence of any laws to the contrary. Any such right of reimbursement or subrogation provided to the Plan shall not apply or shall be limited to the extent that the Federal Statutes eliminate or restrict such rights.

DURATION OF COVERAGE

- 18 months beginning the first day of absence from employment due to service in the uniformed services for elections made prior to 12/10/04; or
- 24 months beginning the first day of absence from employment due to service in the uniformed services for elections beginning on or after 12/10/04; or
- The day after the *employee* fails to apply for or return to employment as required by USERRA, after completion of a period of service.

RIGHT TO COLLECT NEEDED INFORMATION

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

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

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

DUTY TO COOPERATE IN GOOD FAITH

You are obliged to cooperate with the *Plan Manager* in order to protect the Plan's recovery rights. Cooperation includes promptly notifying the *Plan Manager* that *you* may have a claim, providing the *Plan Manager* relevant information, and signing and delivering such documents as the *Plan Manager* reasonably request to secure the Plan's recovery rights. *You* agree to obtain the Plan's consent before releasing any party from liability for payment of medical expenses. *You* agree to provide the *Plan Manager* 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 the *Plan Manager* to enforce the Plan's recovery rights and will do nothing after loss to prejudice the Plan's recovery rights.

Reimbursement/Subrogation Continued

You agree that *you* will not attempt to avoid the 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 the *Plan Manager* such notice or cooperation, or any action by the *covered person* resulting in prejudice to the 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, the Plan may deduct from any pending or subsequent claim made under this Plan any amounts the *covered person* owes the Plan until such time as cooperation is provided and the prejudice ceases.

GENERAL PROVISIONS

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

INCONTESTABILITY

After *you* are covered under this Plan without interruption for two years, the Plan cannot contest the validity of *your* coverage except for:

1. Nonpayment of premium;
2. *Your* ineligibility under the Plan;
3. Any Plan provision;
4. Any fraudulent misrepresentation made by *you*; or
5. Any defenses the Plan may have by law.

An independent incontestability period begins for each type of change in coverage or when the Plan requires a new *participant* enrollment form.

This provision only limits the Plan's rights to void *your* coverage after *you* have been covered without interruption for two years.

RIGHT TO REQUEST OVERPAYMENTS

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

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

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

WORKERS' COMPENSATION NOT AFFECTED

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

LEGAL ACTIONS

You cannot bring an action at law or equity to recover a claim until 60 days after *you* have received the Plan's written claim determination. *You* cannot bring such action more than two years after the *expense incurred* date. *You* must exhaust all levels of the Claim Appeal Procedure before *you* may bring an action at law or equity.

General Provisions Continued

ASSIGNMENT

Assignment of benefits may be made only with the *Plan Manager's* consent, except as may be required by applicable law. An assignment is not binding until the *Plan Manager* receives and acknowledges in writing the original or copy of the assignment before payment of the benefit. The *Plan Manager* does not guarantee the legal validity or effect of such assignment.

WORKERS' COMPENSATION

If benefits are paid by the Plan and the Plan determines *you* received Workers' Compensation for the same incident, the Plan will exercise its right to recover against *you* even though:

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

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

MEDICAID

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

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

CONSTRUCTION OF PLAN TERMS

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

PRIVACY OF PROTECTED HEALTH INFORMATION

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

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

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

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

The *Plan Manager* will afford access to *protected health information* in its possession only as necessary to discharge its obligations as a service provider, within the restrictions noted above. However, Plan records that include *protected health information* are the property of the Plan. Information received by the *Plan Manager* is information received on behalf of the Plan.

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

Attn: Joey Payne
University of Kentucky
115 Scovell Hall
Lexington, KY 40506-0064
Telephone: (859) 257-9519 ext. 172

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

Privacy of Protected Health Information Continued

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

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

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

CLAIM APPEAL PROCEDURE

Claim denials will be made within 90 days of receipt of the claim, or within 120 days in special circumstances when an extension of processing time is required.

If the Plan partially or fully denies a claim for benefits submitted by *you* and *you* disagree or do not understand the reasons for this denial, *you* may appeal this decision. *You* have the right to:

1. Request a review of the denial;
2. Review pertinent Plan documents; and
3. Submit in writing, any data, documents, or comments which are relevant to the Plan's review of this denial.

Your appeal must be submitted in writing within 60 days of receiving written notice of denial. The Plan will review all information and send a written decision on the appeal within 60 days of the Plan's receipt of *your* request, or within 120 days in special circumstances when an extension of processing time is required.

GRIEVANCE PROCEDURES

The plan shall provide a four-step grievance process to resolve *participant* concerns. *You* must exhaust all levels of the claims appeal procedure before *you* may file a legal action.

Step 1: Informal Inquiry. *Participants* shall have sixty (60) days from the receipt of a denial or other action giving rise to make a verbal complaint under this Grievance Process by contacting the Plan Administrator. An appropriate individual knowledgeable about employee benefits matters shall be authorized to render a decision, and notify the *participant* of the outcome within seven (7) working days of receipt of the inquiry.

Participants shall be advised that in the event a problem is not settled at the informal level, the decision may be appealed within sixty (60) days by the *participant* by submitting a written statement to the Plan Administrator Grievance and Appeals Department, which shall include a summary of the complaint, a description of any previous contact made with the plan regarding the matter in question, and a description of the relief sought.

Step 2: Written Appeal. In the event a matter is appealed, it shall be fully investigated by or on behalf of the plan, including, without limitation, a review of all medical records, reports, correspondence, and plan provisions and other documents relevant to the claim and grievance (Grievance File). The *participant* shall be notified in writing of the decision within thirty (30) days after the plan's receipt of the written grievance statement. The investigation may include, as appropriate, consultation with a medical advisor.

Participants shall be advised that, in the event they remain dissatisfied with the written response provided on appeal, the *participant* may submit written requests within sixty (60) days to the plan manager for a hearing before the Grievance and Appeal Committee. *Participants* shall also be advised that they may submit any information they wish the Grievance Committee to consider.

Grievance Hearing Continued

Step 3: Formal Grievance Hearing. The Grievance and Appeals Committee shall be composed of an odd number of members, at least three (3) and no more than five (5) members, all of whom shall be knowledgeable about the plan terms, and at least one of whom shall be a physician, and another of whom shall be knowledgeable about and experienced in employee benefits administration. No member of the Grievance and Appeals Committee shall be a financial officer with or on behalf of the plan. Members of the Grievance and Appeals Committee shall independently review the appeals decision, the entire Grievance File, and any additional evidence presented for or at the hearing and provide the *participant* with a written decision within sixty (60) days after the request for hearing. Members of the Grievance and Appeals Committee shall have no contact with the *participant* regarding the matter under review prior to the hearing and shall not have participated in any prior decision-making or discussions about the matter in advance of such committee's formal review.

Participants shall be advised that, in the event they still remain dissatisfied with the written response provided by the Grievance and Appeals Committee, the *participant* may submit written requests within sixty (60) days to the University of Kentucky Associate Vice President, Human Resource Services.

Step 4: Final Appeal. The University of Kentucky Associate Vice President, Human Resource Services and/or any committee established as set forth below shall have the discretion and power to construe the plan and its terms, to determine questions, including factual questions, relating to payment of benefits, and to decide all questions arising in connection with the plan, including but not limited to eligibility and entitlement to benefits. All actions, determinations or decisions of the Director shall be final, conclusive, binding on all persons.

The Associate Vice President, Human Resource Services shall have the discretion to establish a committee to perform the Final Internal Appeal described in this Step 4, which committee shall satisfy the criteria regarding composition and independence described above in Step 3. The Associate Vice President, Human Resource Services, or the committee so established, as applicable, shall review the entire Grievance File, including prior decisions rendered on the matter under review, and may request additional information from the *participants*, prior to rendering the Final Appeal decision, within thirty (30) days of request for same.

University of Kentucky Prescription Drug Benefit Program Summary Plan Description (July 2006-June 2007)

Introduction
Definitions
Services and Benefits
Limits to Covered Prescription Drug Benefit
Excluded Prescription Drugs
Member Appeals Process
Contact Information
Termination of Coverage

INTRODUCTION

The Prescription Drug Benefit Program is available to UK employees, UK retirees and dependents that are enrolled as plan participants in the UK-HMO, UK-PPO, UK-PPO High, UK-EPO, UK-Health First or the UK-Indemnity Health Plan options. There is one universal prescription benefit that is administered directly by the University instead of through the medical plan (CHA-Health or Humana). Enrollment in the prescription drug benefit program is automatic with the Member's enrollment on any of the UK Health Plans. The Member will have a separate prescription drug benefit identification card from Express Scripts which must be presented to the pharmacist at the time of service. A ten-digit ID number (not the social security number) is assigned to the plan member. If the plan member has a covered spouse and/or dependent(s), this same ten-digit ID is used for each respective plan participant, with a different two-digit suffix (i.e. plan member – "00", spouse/dependent – "01", etc.)

Prescription drug benefits are payable for covered prescription expenses incurred by the Member and the Member's covered dependents. Benefits are payable for such expenses for charges made by a participating pharmacy for each separate prescription, subject to the applicable co-payment or coinsurance as shown in the *Schedule of Benefits*.

Express Scripts is the pharmacy benefit manager.

How to fill your prescription:

- **At your local participating pharmacy:** You will be able to obtain your immediate need (30-day supply) prescriptions through Express Scripts national network of chain and independent retail pharmacies.
- **Through Express Scripts Mail Service Pharmacy:** You will be able to receive your chronic need medications (up to a 90-day supply) by **mail service**. Your medications will be delivered free of shipping costs within two weeks. You will be charged for overnight or two-day delivery when you request such service. You will be able to track these prescriptions on the Express Scripts Web site, and can reorder them by phone, mail or online (www.express-scripts.com).
- **Through Kentucky Clinic Pharmacy:** You will be able to obtain *both* your immediate need (30-day supply) prescriptions AND your chronic need (up to 90-day supply) prescriptions at the Kentucky Clinic Pharmacy ONLY if these prescriptions have been written by a UK prescriber.

DEFINITIONS

Ancillary Charge: A charge in addition to the Co-payment / Coinsurance which the member is required to pay to a Participating Pharmacy for a covered Brand name Prescription Drug Product for which a Generic substitute is available. The Ancillary Charge is calculated as the difference between the Pharmacy Payment Rate for the Brand name Prescription Drug Product dispensed and the Maximum Allowable Cost (MAC) of the Generic substitute.

Average Wholesale Price (AWP): The standardized cost of a drug product, calculated by averaging the cost of an undiscounted drug product charged to a drug wholesaler by a pharmaceutical manufacturer. AWP is as shown in the Express Scripts drug price file and as generally determined by "First Databank".

Brand: A patent-protected Prescription Drug Product that is manufactured and marketed under a trademark, proprietary or non-proprietary name by a specific drug manufacturer. (When manufacturers create new medications, they apply for a patent. After the patent expires, the FDA may approve other manufacturers to produce generic equivalents of the drug.)

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

Coinsurance: The percentage of the eligible expense for each separate prescription order or refill of a covered drug when dispensed by a participating pharmacy. The percentage coinsurance is based on the Pharmacy Payment rate if the Member utilizes a Participating Pharmacy and the Pharmacy submits the claim to Express Scripts electronically. The Member is responsible for payment of the Coinsurance at the point of service. Coinsurance may also be known as a percentage Co-payment.

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

Co-pay (Co-payment): The amount to be paid by you toward the cost of each separate prescription order or refill of a covered drug when dispensed by a participating pharmacy. A "flat dollar" Co-pay is a fixed dollar amount paid by the member when the prescription is filled. The member's Co-payment for a covered drug at a Participating Pharmacy shall be the lesser of the applicable Co-payment or the pharmacy submitted usual and customary charge. The Member is responsible for payment of the Co-pay at the point of service. Coinsurance may also be known as a percentage Co-payment.

Dependents: The individuals (usually spouse and children) that are included in the primary cardholder's benefit coverage.

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

Express Scripts CuraScript Program: a specialty pharmacy management program specializing in the provision of high-cost biotech and other injectable drugs. Express Scripts defines specialty injectable drugs in this category as injectable drugs that have an AWP of \$500 or greater per 30 day prescription.

Formulary: A formulary is a clinically-based drug list that contains FDA-approved brand-name and generic drugs. Formularies are developed based on clinical attributes, as well as cost-effectiveness of products. Members will get the greatest value from their prescription drug benefit when they receive

generic or brand-name drugs that are on the formulary. A formulary may also be referred to as a preferred drug list.

DEFINITIONS (continued)

A copy of the 2006-2007 University of Kentucky Formulary is on-line at <http://www.uky.edu/HR/benefits/prescriptionbenefit.html> or by calling University of Kentucky Employee Benefits.

Formulary Brand: A brand-name drug that is listed on your formulary. It may also be referred to as a preferred brand drug.

Generic: A drug that is chemically equivalent to a brand drug for which the patent has expired. The color and shape of the drug may be different, but the active ingredients are the same. Generic medications are required to meet the same quality standards as brand drugs.

Investigational: Any drug, device, supply, treatment, procedure, facility, equipment or service that is being studied to determine if it should be used for patient care or if it is effective. Something that is Investigational is not recognized as effective medical practice. We reserve the sole right to determine what Investigational is. Approval by the Food and Drug Administration (FDA) does not mean that we approve the service or supply. Drugs classified as Treatment Investigational New Drugs by the FDA are Investigational. Devices with the FDA Investigational Device Exemption and any services involved in clinical trials are Investigational.

Legend Drugs: A drug that can be obtained only by prescription order and bears the label “Caution: federal law prohibits dispensing without a prescription.”

List of Drugs: See Formulary.

Local Pharmacy: See Participating Pharmacy.

Maximum Allowable Cost (MAC list): A maximum reimbursement amount. It is a list of Prescription Drug Products covered at a Generic product price. The MAC list applies to certain generic drug prescription products, but it also applies (under certain conditions) to multi-source products depending upon the DAW code submitted with the claim. This list is distributed to Participating Pharmacies and is subject to periodic review and modification.

Mail Pharmacy: A pharmacy that provides long-term supplies of maintenance medications via mail. Members usually pay less for these medications than they would if obtained from a local participating pharmacy.

Mail Service Benefit: A benefit that allows members to order long-term supplies of maintenance medications via mail. Members usually pay less for these medications than they would if obtained from a local participating pharmacy.

Maintenance medication: Prescription drugs, medicines or medications that are generally prescribed for treatment of long-term chronic sickness or bodily injuries, and, purchased from the pharmacy contracted by the Plan Manager to dispense drugs.

Member: An individual eligible for benefits under the Plan as determined by University of Kentucky Employee Benefits.

Member-Submitted Claims: Paper claims submitted by a Member for Prescription orders or refills at a Participating Pharmacy when the claim is not processed on-line electronically by Express Scripts (e.g., when eligibility cannot be verified at the point of service); such claims are to be reimbursed based on the Member Payment rate, adjusted for Co-pay, Coinsurance and Ancillary Charges.

DEFINITIONS (continued)

Multi-source Brand: A brand-name medication for which there is a chemically equivalent product available.

Non-Covered Drugs: Drugs excluded from coverage include but are not limited to: drugs which can be purchased without a written prescription (over the counter drugs), non-FDA approved and experimental (investigational) drugs, medications used exclusively for cosmetic purposes, medications used in the treatment of a non-covered diagnosis (benefit) such as weight loss, smoking cessation, sexual dysfunction, and infertility. Replacement of lost or stolen medications is not covered.

Non-Participating Pharmacy: A pharmacy which has not entered into an agreement with the Plan Manager to participate as part of the Express Scripts Pharmacy Network.

Non-Formulary Brand: A brand-name drug that is not listed on your formulary. Also referred to as a non-preferred brand drug.

Non-Preferred Brand: Drugs found not to have a significant therapeutic advantage over the Preferred Brand drug. Also referred to as a non-formulary brand drug.

Over-the-counter (OTC) drug: A drug product that does not require a Prescription Order under federal or state law.

Out-of-Network Coverage: Your pharmacy benefit program does not allow for out-of-network coverage.

Participating Pharmacy: A pharmacy that has contractually agreed to provide prescription drug products to eligible members of a prescription benefit plan. Members must purchase their prescription drugs from a participating pharmacy to receive the coverage provided by the prescription benefit. The pharmacy will accept as payment the Co-payment / Coinsurance amount to be paid by you and the amount of the benefit payment provided by the Plan.

Participant: any covered person, who is properly enrolled in the Plan.

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

Pharmacy and Therapeutics (P&T) Committee: An organized panel of physicians and pharmacists from varying practice specialties, who function as an advisory panel to the Express Scripts benefit programs regarding the safe and effective use of prescription medications.

Pharmacy Payment Rate: The payment a Participating Pharmacy is entitled to receive, including any dispensing fee, for a particular Prescription Drug Product dispensed to a Member according to the terms of the applicable pharmacy provider contract, when the claim is processed on-line electronically by Express Scripts (or, on an exception basis, a Participating Pharmacy is allowed to submit paper claims to Express Scripts).

Plan Administrator: the University of Kentucky.

Plan Manager: see Prescription Benefit Manager.

Plan Year: 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.

DEFINITIONS (continued)

Preferred Brand Drug: A brand-name drug that is listed on your formulary. It is also referred to as a formulary brand drug.

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

- Name and address of the covered person for whom the prescription is intended
- Type and quantity of the drug, medicine or medication prescribed, and the directions for its use.
- Date the prescription was prescribed
- Name, address and license number of the prescribing qualified practitioner

Prescription Benefit Manager (PBM): Express Scripts. The PBM provides services to the Plan Administrator, as defined under the Plan Management Agreement. The Plan Manager is not the Plan Administrator.

Prescription Drug Product: A medication, product or device approved by the FDA and dispensed under federal or state law only pursuant to a Prescription Order or Refill. This definition also includes insulin and certain diabetic supplies if dispensed pursuant to a Prescription Order or Refill.

Prescription Order or Refill: The directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

Prior Authorization: The required prior approval from the Plan Manager for the coverage of prescription drugs, medicines, medications, including the dosage, quantity and duration, as appropriate for the covered person's age and sex. Certain prescription drugs, medicines or medications may require prior authorization.

Single-Source Brand: A brand medication for which there is no generic version available.

Therapeutic Equivalent: A medication that can be expected to have the same clinical effect and safety profile when administered under the conditions specified in labeling as another medication, although the medications are not Chemical Equivalents.

Usual and Customary (U&C) Charge: The usual and customary price charged by a pharmacy for a Prescription Drug Product dispensed to a cash paying customer.

SERVICES AND BENEFITS

Schedule of Benefits

	1-month supply local pharmacy	1-month supply local pharmacy	1-month supply local pharmacy	3-month supply mail service or KY Clinic Pharmacy	3-month supply mail service or KY Clinic Pharmacy	3-month supply mail service or KY Clinic Pharmacy
	coinsurance	minimum	maximum	coinsurance	minimum	maximum
Generic	30%	\$8.00	\$50.00	20%	\$24.00	\$100.00
Formulary Brand	40%	\$20.00	\$60.00	30%	\$60.00	\$120.00
Non- Formulary Brand	50%	\$40.00	\$100.00	40%	\$120.00	\$200.00

Retail Prescription Program

Drugs that are prescribed for short-term use (up to a 30-day supply) should be filled using the retail drug card. The Retail Prescription Drug Card Program is administered by Express Scripts. Participants are provided a prescription drug card to purchase drugs from a local pharmacy that participates in the Express Scripts Network. This network includes over 53,000 pharmacies nationwide. These include most chain or grocery stores such as Wal-Mart or Kroger as well as many independent pharmacies across the nation. Confirmation of participating pharmacies may be obtained by calling Express Scripts at 1-877-242-1864 or through the web site at www.express-scripts.com.

The amount of the coinsurance or co-payment is dependent upon whether the prescription is for a generic, a formulary brand name drug or a non-formulary brand name drug. A generic drug is identical in chemical composition to its brand name counterpart, has been approved by the Food and Drug Administration to be therapeutically equivalent, and is as effective as the brand name product. The use of generics and formulary brand name drugs help to keep the cost of prescription drugs down for both the participant and the plan. All non-formulary drugs have alternatives available; preferred brand name drugs and possibly generics, both of which are more, cost effective.

As a participant in this program, you must pay for:

- The cost of medication not covered under the prescription benefit;
- The cost of any quantity of medication dispensed in excess of a consecutive 30-day non-maintenance medication supply.

SERVICES AND BENEFITS (continued)

A copy of the 2006-2007 University of Kentucky Formulary is on-line at <http://www.uky.edu/HR/benefits/prescriptionbenefit.html> or by calling University of Kentucky Employee Benefits.

The Co-payments or Coinsurance for each type **Retail (30-day)** prescription at your local participating pharmacy are:

- Generic: 30% or minimum of \$8.00
- Formulary Brand Name Drug: 40% or minimum of \$20.00
- Non-Formulary Brand Name Drug: 50% or minimum of \$40.00

The out of pocket maximum is \$60 per prescription for generic or formulary brand name drugs (excluding non-formulary drugs which are subject to an out-of-pocket limit of \$100 per prescription). There is a mandatory generic program. If the Member does not accept the generic equivalent for a “brand name” drug when one exists, the Member will be responsible for the applicable brand name Co-pay or coinsurance, plus any cost difference between the brand name and generic drug up to the retail price of the requested drug.

Each retail prescription is limited to a 30-day supply. However if the medical condition is such that the prescription drug is to be taken over a prolonged period of time (month or even years) it may be more financially advantageous to use the mail order program described below.

Reimbursement for prescriptions purchased at non-network pharmacies will not be reimbursed under your prescription benefit, and are the financial responsibility of the Member.

All paper claims incurred during the calendar year must be submitted within 120 days of the original date of service. Any claims received after that date will be denied.

Pharmacy benefit Co-payments and Coinsurance cannot be applied toward the deductibles or out-of-pocket limits of the medical plans (UK-HMO, UK-PPO, UK-PPO High, UK-EPO, UK-Indemnity, or UK-Health First).

Mail Service Prescription Program

The mail order program is designed for individuals who take the same medication over a long period of time for conditions such as diabetes, high blood pressure, ulcers, emphysema, arthritis, heart or thyroid conditions. While it is not mandatory to use the mail order program, those that do will reduce their out of pocket payments and will not have to reorder as frequently.

The Co-payments or Coinsurance for each type **Mail Service** prescription (**for a 1 to 34 day supply**) are the **same as outlined under the Retail Prescription Program above**.

The Co-payments or Coinsurance for each type **Mail Service** prescription (**for a 35 to 90-day supply**) are:

- Generic: 20% or minimum of \$24.00
- Formulary Brand Name Drug: 30% or minimum of \$60.00
- Non Formulary Brand Name Drug: 40% or minimum of \$120.00

The out of pocket maximum is \$100 per generic prescription and \$120 per formulary brand name prescription (excluding non-formulary drugs which are subject to an out-of-pocket limit of \$200 per prescription). There is a mandatory generic program. If the Member does not accept the generic equivalent for a “brand name” drug when one exists, the Member will be responsible for the applicable brand name Co-pay or Coinsurance, plus any cost difference between the brand name and generic drug up to the retail price of the requested drug.

Each mail service prescription is limited to a maximum quantity limit of a 90-day supply. Express Scripts is required by law to dispense the prescription in the exact quantity specified by the physician. Therefore if the quantity prescribed is for less than 90 days per refill Express Scripts will fill that exact quantity.

To place an initial order through the mail service drug program a Mail Service Enrollment Order Form must be completed and submitted to Express Scripts along with the original prescription(s) and the appropriate payment. Order forms for the mail service prescription drug program are available from Express Scripts or the University of Kentucky Employee Benefits.

Refills for maintenance medications through the mail order pharmacy can be obtained by phone at 1-877-242-1864, or through the Express Scripts web site at www.express-scripts.com.

Kentucky Clinic Pharmacy

If you are under the care of a UK Provider, you will be able to obtain both your immediate need (30-day supply) prescriptions AND your chronic need (up to 90-day supply) prescriptions at the Kentucky Clinic Pharmacy, on a walk-up (in person) basis. The web site is https://www.hosp.uky.edu/pharmacy/OutpatientPharmacy_refill.html

Covered Prescription Drugs (continued)

Special Procedure for Injectable Medications:

Express Scripts CuraScript Specialty Pharmacy is a specialty pharmacy management program specializing in the provision of high-cost biotech and other injectable drugs used to treat long-term chronic disease states via the CuraScript Pharmacy. The retail pharmacy of the Member's choice will be able to dispense the first injection prescription and then the Member will be required to obtain subsequent doses from CuraScript Specialty Pharmacy. As an alternative pharmacy to CuraScript, the Member may also use the Kentucky Clinic Pharmacy if you are under the care of a UK Provider. These medications include, but are not limited to, Pegasys, PEG-Intron, Avonex, Betaseron, Copaxone, Humira, Enbrel, Neupogen, Fragmin, and Lovenox.

There are other medications which include, but are not limited to, Synagis, Remicade, Lupron Depot, and Synvisc that are NOT available on a first-dose basis from the retail pharmacy, but may ONLY be obtained from the Kentucky Clinic Pharmacy or Express Scripts CuraScript program.

There are other injectable medications that may be administered only by the physician. Coverage status of these medications as a pharmacy benefit versus medical benefit is subject to review and prior-approval by the Plan.

Covered Prescription Drugs

1. Covered prescription drugs, medicines or medications must
 - a. Be prescribed by a qualified practitioner for the treatment of a sickness or bodily injury;
 - b. Be dispensed by a pharmacist;
 - c. Require a prescription by federal law unless otherwise excluded.
2. Benefits are provided for Medically Necessary Prescription Drugs and medicines incidental to care of an Outpatient.
3. All compound medications containing at least one prescription ingredient in a therapeutic amount.
4. Injectable insulin when prescribed by a physician, including diabetic supplies (needles, syringes, test strips, lancets, pens).
5. Aerochambers, spacers, peak flow meters;
6. Self-administered injectable drugs, limited to those approved by the Prescription Benefit, and available through the Participating Pharmacies or Express Scripts Curascript program;

Covered Prescription Drugs (continued)

7. Selected high-cost Injectable drugs intended for administration in a Provider's office may be covered ONLY if pre-approved by the Plan and obtained ONLY through the Kentucky Clinic Pharmacy or Express Scripts Curascript Pharmacy program.
8. Oral contraceptives;
9. Special Foods for Inborn Errors of Metabolism: Amino acid modified preparations and low-protein modified food products for the treatment of inherited metabolic diseases if the amino acid products are prescribed for the therapeutic treatment of inherited metabolic diseases and administered under the direction of a physician.
 - a. Coverage for amino acid modified preparations and infant formulas are subject, for each Plan Year, to a cap of twenty-five thousand dollars (\$25,000), and low-protein modified food products shall be subject, for each Plan Year, to a cap of four thousand (\$4,000), subject to annual inflation adjustments.
 - b. Covered services under this section are for the following conditions: (1) Phenylketonuria; (2) Hyperphenylalaninemia; (3) Tyrosinemia (types I, II and III); (4) Maple syrup urine disease; (5) A-ketoacid dehydrogenase deficiency; (6) Isovaleryl-CoA dehydrogenase deficiency; (7) 3-methylcrotonyl-CoA carboxylase deficiency; (8) 3-methylglutaconyl-CoA hydratase deficiency; (9) 3-hydroxy-3-methylglutaryl-CoA lyase deficiency (HMG-CoA lyase deficiency); (10) b-ketothiolase deficiency; (11) Homocystinuria; (12) Glutaric aciduria (types I and II); (13) Lysinuric protein intolerance; (14) Non-ketotic hyperglycinemia; (15) Propionic acidemia; (16) Gyrate atrophy; (17) Hyperornithinemia / hyperammonemia / homocitrullinuria syndrome; (18) Carbamoyl phosphate synthetase deficiency; (19) Ornithine carbamoyl transferase deficiency; (20) Citrullinemia; (21) Arginosuccinic aciduria; (22) Methylmalonic acidemia; and (23) Argininemia.
 - c. The Member should use Participating Pharmacies for prescription products and special supplements. If the purchase of such foods is from a supplier who will not bill Express Scripts, the Member should submit the detailed receipt along with a copy of the prescription to University of Kentucky Employee Benefits Customer Service for reimbursement.

Covered Prescription Drugs (continued)

LIMITS TO COVERED PRESCRIPTION DRUG BENEFIT

1. The covered benefit for any one prescription will be limited to:
 - a. Quantities that can reasonably be expected to be consumed or used within 30 days or as otherwise authorized by the Plan;
 - b. Refills only up to the number specified by a physician;
 - c. Refills up to one year from the date of the initial prescription order.
2. Certain prescription drugs require prior-authorization in accordance to guidelines adopted by Express Scripts, including but not limited to: growth hormones, Epogen/Procrit, Botox, Prolastin, itraconazole capsules, Lamisil tablets, Regranex, Aranesp.
3. Inclusion of a particular medication on the Preferred Drug List is not a guarantee of coverage. The level of benefits received is based on your prescription drug benefit and the Preferred Drug List status of each drug at the time the prescription is filled. The Plan reserves the right to reassign drugs to a different level or non-formulary status at any time during the plan year. The Plan also reserves the right to change quantity limits or prior authorization status during the plan year.
4. Certain medical supplies and drugs may be separate from the Prescription Drug Benefit. Members may not obtain these items as pharmacy benefits using the Plan's prescription benefit. The supplier of these items must submit a claim directly to CHA-Health or Humana Health Plans.

EXCLUDED PRESCRIPTION DRUGS

1. Over the counter products that may be purchased without a written prescription or their equivalents. This includes those drugs or medicines which become available without a prescription having previously required a prescription. This does not apply to injectable insulin, insulin syringes and needles and diabetic supplies, which are specifically included.
2. Over the Counter equivalents: As determined by the Prescription Benefit, these are selected prescription drugs (legend drugs) according to First DataBank (FDB) with OTC equivalent product(s) available.
 - a. These products have a similar OTC product which has an identical strength, an identical route of administration, identical active chemical ingredient(s), and an identical dosage form (exceptions may be made for similar oral liquid dosage forms); (e.g., Niferex-150, Lac-Hydrin, benzoyl peroxide products, Lamisil, Lamisil AT, Lotrimin AF).

Excluded Prescription Drugs (Continued)

- b. These products have a similar OTC product which has an identical systemic strength (for orally administered medications; or can achieve an identical systemic strength by using multiples of the OTC product [reserved for select products]), same route of administration, same active chemical ingredient (variations of salt forms included), and a similar dosage form. Topically administered legend products may not have the same strength (concentration) as their similar OTC equivalent, but will reside within or near a range of strengths available (lower strength legend products will be included if there are higher strength OTC products available) for similar OTC equivalent products (e.g., benzoyl peroxide products, lidocaine products).
3. Therapeutic devices or appliances, even though such devices may require a prescription including (but not limited to):
 - a. Hypodermic needles, syringes, (except needles and syringes for diabetes);
 - b. Support garments;
 - c. Test reagents;
 - d. Mechanical pumps for delivery of medications and ancillary pump products;
 - e. Implantable insulin pumps;
 - f. Other non medical substances;
 - g. Durable medical equipment
4. Injectable drugs, including but not limited to:
 - a. Immunization agents;
 - b. Biological serum; Vaccines;
 - c. Blood or blood plasma; or
 - d. Self administered medications not indicated in covered prescription drugs.
 - e. Injectable drugs intended for administration in a Provider's office or other medical facilities are NOT covered if purchased by a Member directly from a retail pharmacy.
5. Any oral drug or medicine or medication that is consumed or injected, at the place where the prescription is given, or dispensed by the qualified practitioner;
6. Contraceptives, other than oral or injection, whether medication or device, regardless of the purpose for which they are prescribed (e.g., diaphragms, IUDs);
7. Implantable time-released medications or drug delivery implants.
8. Abortifacients (drugs used to induce abortions – refer to medical benefit for life threatening abortion coverage);
9. Experimental or investigational drugs or drugs prescribed for experimental, non-FDA approved, indications.
10. Any drug prescribed for intended use other than for:
 - a. Indications approved by the FDA; or
 - b. Recognized off-label indications through peer-reviewed medical literature;

Excluded Prescription Drugs (Continued)

11. Compound chemical ingredients or combination of federal legend drugs in a non-FDA approved dosage form. Drugs, including compounded drugs, which are not FDA approved for treatment for a specified category of medical conditions, unless the Plan determines such use is consistent with standard medical practice and has been effective in published peer review medical literature as to leading to improvement in health outcomes.
12. Dietary supplements, nutritional products, or nutritional supplements except for hereditary metabolic diseases only;
13. Herbs, minerals, fluoride supplements and vitamins, except prenatal (including greater than one milligram of folic acid) and pediatric multi-vitamins with fluoride;
14. Progesterone crystals or powder in any compounded dosage form;
15. Allergen extracts;
16. Anabolic steroids;
17. Treatment for onychomycosis (nail fungus), except for immunocompromised or diabetic patients;
18. Medications used in the treatment of a non-covered diagnosis.
19. Any drug used for infertility purposes, including but not limited to oral, vaginal or injectable (e.g., Clomid, Crinone, Profasi, and HCG).
20. Any drug used for cosmetic purposes, including but not limited to:
 - Tretinoin (e.g., Retin A), except if you are under age 30 or are diagnosed as having adult acne;
 - Anti wrinkle agents or photo-aged skin products (e.g., Renova, Avage);
 - Dermatological or hair growth stimulants (e.g., Propecia, Vaniqa);
 - Pigmenting or de-pigmenting agents (e.g., Solaquin);
 - Injectable cosmetics (e.g., Botox)
21. Anorectic or any drug used for the purpose of weight reduction or weight control, suppress appetite or control fat absorption, including, but not limited to, Adderall, Dexedrine, Meridia, Xenical.
22. Any drug prescribed for impotence and or sexual dysfunction, (e.g., Muse, Viagra, Cialis, Caverject, Edex, Yohimbine, clomiphene).
23. Any service, supply or therapy to eliminate or reduce a dependency on or addiction to tobacco and tobacco products, including but not limited to nicotine withdrawal therapies or smoking cessation medications.

Excluded Prescription Drugs (Continued)

24. For prescription drugs:
 - In a quantity which is in excess of a 30 day supply obtained at a retail pharmacy;
 - In a quantity which is in excess of a 90 day mail order supply;
 - In a quantity which is in excess of the amount prescribed;
25. Replacement of lost or stolen medications is not covered.
26. Drugs obtained at a non-participating provider pharmacy.
27. Any drug for which a charge is customarily not made, or for which the dispenser's charge is less than the co-payment amount in the absence of this benefit.
28. Prescriptions that are to be taken by or administered to the covered person, in whole or in part, while he or she is a Member in a facility where drugs are ordinarily provided by the facility on an inpatient basis, are not covered. Inpatient facilities include, but are not limited to:
 - Hospital;
 - Rest home;
 - Sanitarium;
 - Skilled nursing facility;
 - Convalescent hospital;
 - Hospice facility.
29. Benefits are not provided for medication used by an Outpatient to maintain drug addiction or drug dependency, Methadone Maintenance Program or medications which are excessive or abusive for your condition or diagnosis.
30. The Plan Manager may decline coverage of a specific medication or, if applicable, drug list inclusion of any and all drugs, medicines or medications until the conclusion of a review period not to exceed six (6) months following FDA approval for the use and release of the drug, medicine or medication into the market.
31. Items that may be covered by state or federal programs, such as items covered by Worker's Compensation.
32. Expense incurred will not be payable for the following:
 - Legend drugs which are not recommended and not deemed necessary by a prescriber;
 - The administration of covered medication;
 - Any drug, medicine or medication received by the covered person before becoming covered under the Plan; or after the date the covered person's coverage under the Plan has ended;
 - Any drug, medicine or medication labeled "Caution-limited by Federal Law to investigational use" or any experimental drug, medicine or medication, even though a charge is made to the covered person;
 - Any costs related to the mailing, sending or delivery of prescription drugs;

Excluded Prescription Drugs (Continued)

- Any fraudulent misuse of this benefit including prescriptions purchased for consumption by someone other than the covered person;
- Prescription or refill for drugs, medicines or medications that are lost, stolen, spilled, spoiled or damaged;
- More than one prescription for the same drug or therapeutic equivalent medication prescribed by one or more Qualified Practitioners and dispensed by one or more Pharmacies until at least 75% of the previous Prescription has been used by the Covered Person, unless the drug or therapeutic equivalent medication is dispensed at a mail order service in which case 66% of the previous Prescription must have been used by the covered person;
- Any drug or biological that has received an “orphan drug” designation, unless approved by the Plan;
- Any Co-payment or Coinsurance you paid for a prescription that has been filled, regardless of whether the Prescription is revoked or changed due to adverse reaction or change in dosage or Prescription.

MEMBER COMPLAINT AND APPEAL PROCESS

There is a formal complaint and appeal process for handling Member concerns. A complaint is an oral or written expression of dissatisfaction. An appeal is a request to change a previous decision made by Express-Scripts for the Prescription Benefit. Below is the four-step appeal process for you to follow to resolve your issue. You must exhaust your appeal rights under the Member Complaint and Appeal Process prior to bringing any other administrative or legal action.

Step 1 – Informal Inquiry

We recommend that you always contact Express Scripts Customer Service first when you have a problem, concern or complaint. The Customer Service toll-free number is 1-877-242-1864 (or 1-800-972-4348 for hearing-impaired).

Many problems can be resolved the same day. If not, Customer Services will investigate and notify you of our findings and any action taken. If additional time is needed to respond to your complaint, we will notify you that additional days are required to resolve your complaint. If your complaint is related to a denial of coverage by the Plan, you may file an appeal.

Step 2 – Written Appeal

If the inquiry or complaint of the Member has not been resolved informally under Step 1, the Member may request a formal review. Any such request shall be submitted in writing within 60 days after the date of the denial notice. If the Plan denies medical necessity coverage for a Prescription Drug Product, you may appeal. You may also appeal if the Plan does not issue a timely decision.

Member may appeal any medical necessity claim denial to Express Scripts within 60 days of denial. Express Scripts will review appeal request and provide a written response to the member within 30 days of written request to Express Scripts.

Member Complaint And Appeal Process (Continued)

The letter should be signed by the Member and include the following information:

- Your name if applicable, the name of the person acting on your behalf.
- Your Prescription Benefit Identification Number, address, telephone number. Please include the best time to reach you.
- The service being denied. Include all the facts and issues related to the denial, the names of providers involved with your and medical records, if applicable.
- The resolution you are requesting.
- If you wish another person to represent you in the appeal, enclose a signed statement designating that person as your representative. You may obtain a Personal Representative form from UK Employee Benefits Customer Service.

Step 3 – Formal Appeal Committee

If the Member is not satisfied with the resolution or determination, he/she may submit a written request for a hearing to Express Scripts Appeals Committee. The written request must be sent within 60 days of receipt of the appeal decision letter under Step 2 of this Appeal Procedure. The Member may submit in writing any relevant information he or she wishes the Committee to consider at this level.

The Committee reviewing the appeal will be provided with the applicable medical records, plan language and any documentation regarding any previous appeals. You will be notified within one business day of receipt of case to inform you of your right to submit additional records for review. You will also be provided the name and telephone number of a contact person to answer questions related to the appeal process. Your medical provider may be contacted for additional information as well. You will be notified of the determination of your appeal within 60 days.

Step 4 – Final Appeal

If you are not satisfied with the outcome of the Appeal Committee, you may submit a written request within 60 days of receipt of the Appeal Committee decision letter under Step 3, to the Associate Vice President, Human Resource Services at the University of Kentucky, 101 Scovell Hall, Lexington, KY 40506-0064. The statement should include a summary of the complaint or issue, information regarding previous contact(s) with the Plan regarding the matter in question and a description of the relief sought. The Associate Vice President, Human Resource Services has the discretion to establish a Committee to perform the Final Appeal process. The Associate Vice President, Human Resource Services, and/or the Committee so established, as applicable, shall review the entire appeal file, including prior decisions rendered on the matter under review, and may request additional information from the Member, prior to rendering the final appeal decision. The final appeal decision will be rendered within 30 days of request of the formal appeal.

CONTACT INFORMATION

If you have questions about the retail drug program, the mail order program or your prescription order, please call the Express-Scripts toll free customer service number at 1-877-242-1864 (or 1-800-899-2114 for hearing impaired). These toll-free numbers are listed on the back of your pharmacy benefit member identification card.

You may also obtain information by calling University of Kentucky Employee Benefits Customer Service, or by going to the web site address: <http://www.uky.edu/HR/benefits> or <http://www.uky.edu/HR/benefits/prescriptionbenefit.html> and click on the available links to access the type of information you need. You may also contact the UK Prescription Benefit Pharmacists in the UK Employee Benefits Office.

TERMINATION OF COVERAGE

Coverage under this plan will terminate on the date a participant is no longer enrolled in a covered University of Kentucky Health Plans (UK-HMO, UK-PPO, UK-PPO High, UK-EPO, UK-Indemnity, or UK-Health First).