GROUP ADMINISTRATOR HANDBOOK

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INTRODUCTION

Bluegrass Family Health, Inc. is a not-for-profit Health Maintenance Organization (HMO) that is a subsidiary of the Baptist Healthcare System, Inc. Bluegrass Family Health is committed to delivering comprehensive benefits through a quality and cost-effective delivery system for members and employers. Our goal is to achieve the most positive health care outcomes possible through timely and accessible services, sensitive and supportive delivery of care, and the promotion of healthy lifestyles through education. Bluegrass Family Health offers a variety of benefit plans such as HMO, POS, PPO and Bluegrass Consumer Choice products.

We hope that in conjunction with our qualified staff of employees, this handbook will assist you in the administration of your health plan. Included in the handbook you will find samples of Bluegrass Family Health forms and instructions for their completion. Since completing forms accurately and thoroughly is critical for efficient and prompt service, we ask that you read the instructions carefully. In addition, this handbook also provides answers to the most commonly asked questions regarding plan administration. If you need additional forms or have further questions, contact your Account Service Representative at the following: Lexington (859) 269-4475 or (800) 787-2680 or Louisville (502) 420-2359 or (800) 787-2680.

BENEFIT PLANS

HMO – HEALTH MAINTENANCE ORGANIZATION

Although designation of a Primary Care Physician (PCP) is not required, Bluegrass Family Health encourages Members to use a PCP (Internal Medicine Physicians, Family Practice Physicians and/or Pediatricians) for their day-to-day care. **No referrals** are required for an in-network Specialist. With the exception of a true emergency or prior Plan approval, no benefits will be paid when using non-participating providers on the HMO Plans. **IT IS THE RESPONSIBILITY OF THE MEMBER TO USE PARTICIPATING PHYSICIANS AND FACILITIES.**

POS – POINT OF SERVICE PLAN

The POS Plan does not require the Member to select a PCP from the Plan's network, but does encourage the use of a PCP (Internal Medicine Physicians, Family Practice physicians and/or Pediatricians) for their day-to-day care. Referrals to participating or non-participating providers are **NOT** required. Members can self-refer to participating providers and receive in-network benefits for covered services. If the member receives care from a non-participating provider, out-of-network benefits apply with the exception of urgent and emergent care. When the member uses out-of-network benefits, the member is responsible for a copay, co-insurance, excess charges (often referred to as those charges beyond usual, customary and reasonable, UCR) and prior authorization, when required based on the precertification list located in the member's Certification of Coverage. **The member is responsible for ensuring a prior authorization has been obtained. IT IS THE RESPONSIBILITY OF THE MEMBER TO USE PARTICIPATING PROVIDERS IN ORDER TO RECEIVE IN-NETWORK BENEFITS.**

PPO – PREFERRED PROVIDER ORGANIZATION

The PPO Plan does not require Members to choose a PCP or obtain referrals for covered specialty care services. Depending on the service, a copayment, co-insurance and/or deductible could apply. Members may elect to seek services outside of the network, but a higher co-insurance will apply. In addition, out-of-network providers may bill Members for excess charges or those charges beyond usual, customary and reasonable**. The member is responsible for ensuring a prior authorization has been obtained. IT IS THE RESPONSIBILITY OF THE MEMBER TO USE PARTICIPATING PROVIDERS IN ORDER TO RECEIVE IN-NETWORK BENEFITS.**

BLUEGRASS CONSUMER CHOICE

Bluegrass Family Health and Wells Fargo have teamed up to offer one of the latest innovations in the health insurance industry. Bluegrass Consumer Choice combines a Health Reimbursement Arrangement (HRA) with a Preferred Provider Organization (PPO) plan.

This new plan has five major components:

1. **Preventive Care** – 100% first dollar coverage of qualified preventive care services including exams and tests.
2. **HRA** – An employer-sponsored Health Reimbursement Arrangement (HRA) to use wisely toward satisfying your deductible and other qualified expenses.
3. **Employee Responsibility** – Your portion of the deductible co-insurance and non-qualified expenses.
4. **PPO** – A major medical plan to cover eligible health care expenses once the deductible has been reached.
5. **Support Suite** – Web-enabled tools and other services to help you manage your costs and care.

The PPO portion features the same excellent care and service features your employees have come to expect from Bluegrass Family Health. In addition, they will now benefit from an HRA. The HRA is important for two reasons. First, it helps pay for health care expenses as employees meet their deductible. Second, they will have the opportunity to rollover unused dollars for future needs. The HRA is tax advantaged and administered by Wells Fargo, an industry leader in HRA administration and funds management.

EMERGENCY AND URGENT CARE SERVICES

An Emergency Medical Condition is defined as follows in the BFH Certificate of Coverage:

a) A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent lay person would reasonably have cause to believe constitutes a condition that the absence of immediate medical attention could reasonably be expected to result in:
   1. Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy;
   2. Serious impairment to bodily functions; or
   3. Serious dysfunction of any bodily organ or part.

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

If you feel you have an emergent medical condition, you should go to the nearest medical facility for, at least, emergency screening and stabilization services. It is recommended that you notify your Participating Provider within 24 hours or as soon as reasonably possible. Any follow-up care must be provided or supervised by your Participating Provider or approved in advance by the Plan. Emergency Medical Conditions are covered anywhere. **Follow-up care is not considered Emergency Care.**

If you have an emergent medical condition while outside the Service Area, go to the closest facility that can provide the necessary emergent treatment. Should you be hospitalized following an emergency, you or a member of your family must contact the Plan within 24 hours of being admitted or as soon as reasonably possible. If your hospital care is provided in a non-participating hospital, the Plan may make arrangements with your Participating Provider to transfer you to a participating plan facility, if it is medically feasible, and all charges for an approved transfer will be paid by the Plan. Coverage in a non-participating facility will be furnished only until your condition, as determined by your Participating Provider or some other Plan-approved physician, permits your transfer to a participating facility.

Urgent Care is medical care that is appropriate for the treatment of an illness or injury that is not a life-threatening emergency, but requires prompt medical attention. Urgent Care includes the treatment of minor injuries as a result of accidents, the relief or elimination of acute pain, or the moderation of an acute illness. If you require treatment for Urgent Care, you may go to a participating urgent care center. You will be responsible for your copayment amount as specified on the schedule of benefits. If you require treatment for Urgent Care and you are out of the Service Area, you may go to a non-participating urgent care center. Please remember that before treatment is received

at an urgent care center, it must meet the definition of Urgent Care as determined by the Plan. The Plan does not cover out-of-area care which could have been anticipated before you left the Service Area.

If you are traveling outside of the country, benefits are available for Emergency and Urgent Care only. Seek care at the appropriate facility. Once your care is completed, you will need to pay the bill. (You may want to use a credit card. The credit card company will automatically transfer the foreign currency into American dollars for you.) Keep all your receipts! When you return home, contact Customer Service at the number on the back of your ID card. Submit information about your situation along with your receipts in order to receive reimbursement. (The amount submitted must be in American dollars.) You will be reimbursed based on the benefits of your Plan. Please refer to the Exclusions section of the Certificate of Coverage for further information.

PRE-EXISTING CONDITIONS

Services, supplies, or other expenses incurred for a physical or mental condition, regardless of its cause, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 month period ending on the Covered Person's Enrollment Date are excluded from coverage. Such exclusion of coverage for a Pre-Existing Condition may not exceed a period of 12 months following the Enrollment Date. The Pre-Existing Condition exclusion does not apply to (1) pregnancy, (2) genetic information in the absence of a diagnosis, (3) domestic violence, or (4) newborn children or children adopted before the age of 18 if they are enrolled in the Plan within 31 days of the date of the birth, the date the child is legally placed for adoption, or the date the child is legally adopted.

However, the Plan will credit the time the covered person was covered under other Creditable Coverage if the coverage was continuous for 12 months to a date not more than sixty-three (63) days prior to the effective date of hire. Waiting periods set by the employer are not considered a break in coverage.

PHARMACY FACTS

Check the Schedule of Benefits to see if prescription drug coverage is provided on this plan. The Bluegrass Family Health Preferred Drug List has been compiled to respond to the constantly changing nature of drug therapy. The Preferred Drug List is dynamic and subject to change. You will be notified at least 30 days in advance of changes**.**

DRUG UTILIZATION PROGRAM

Bluegrass Family Health's pharmacy benefit is based on the appropriate use of medications. The goal of appropriate use is to provide high quality, safe and effective prescription medication therapy in collaboration with physicians and pharmacists. Under the Drug Utilization Program, prescribed medications are monitored for correct dosing, quantity, length of therapy, inappropriate use, duplicated therapy, and medication interactions. Medications prescribed appropriately can provide one of the most effective means of therapy. However, the inappropriate use of medications may result in costly adverse events due to medication interactions or misuse.

PHARMACY BENEFITS

For **members using the in-network pharmacy benefits,** you must use a participating pharmacy (except in an urgent or emergent situation) to access your Bluegrass Family Health pharmacy benefits. Presenting a valid ID card to the pharmacist is vital! Medications should be processed electronically by your pharmacist. Claims not submitted electronically by a participating pharmacy may not be eligible for reimbursement. For **members who have out-of-network pharmacy benefits,** you must submit a detailed pharmacy receipt to Bluegrass Family Health for reimbursement. ALL requests for reimbursement must be accompanied by 1) a written statement of why the claim was not submitted by the pharmacy, and 2) a pharmacy receipt that includes the name of the medication, the name of the pharmacy where the medication was purchased, the quantity dispensed, the days supply, and the amount the pharmacy charged. You will be reimbursed based on your benefits and the applicable copayment will be deducted from your reimbursement.

If you are at the pharmacy and you do not have your Bluegrass Family Health identification card, or if the pharmacist is having trouble filing the claim online, please instruct the pharmacist to contact the Bluegrass Family Health Pharmacy Services Department at (877) 205-6308 or (859) 335-3755.

BENEFIT EXCLUSIONS

Bluegrass Family Health will not cover, at any copayment tier, any medications prescribed for the treatment of diagnoses that are excluded from coverage. The list of 1st and 2nd tier medications does not provide information regarding the specific coverage rules and limitations on medications. Many members have specific exclusions and copays, which are not reflected in this list. The list applies only to outpatient medications provided to members and does not apply to medications used in inpatient settings. If a member has any specific questions regarding their coverage, they should contact BFH. The following general exclusions pertain to all covered individuals:

A. Over the Counter (OTC) medications or their equivalents are not covered, unless otherwise specified in the list of 1st and 2nd tier medications.
B. Nicotine Smoking Cessation products (i.e., transdermal nicotine, nicotine gum) are not covered.
C. Medication Products specifically listed as not covered.
D. Any medication products used for cosmetic purposes, including hair loss, are not covered.
E. Experimental medication products or any medication product used in an experimental manner, or for conditions not approved by the FDA, are not covered.
F. Replacement of lost, stolen or spilled medication is not covered.
G. Medications on the Prior Plan Approval ***(PPA)*** List that do not meet the medical necessity criteria are not covered.
H. Weight loss medications are not covered.
I. Medications for the treatment of sexual dysfunction are not covered unless specified in plan documentation.
J. Compounded medications that are prepared by a pharmacist and are not FDA-approved in their final form are not covered.
K. Medications not approved by the FDA are not covered.

URGENT AND EMERGENT SITUATIONS

If you are out of the area and need to have a prescription filled for an urgent or emergent condition, for your convenience you may take the prescription and your Bluegrass Family Health identification card to a participating chain pharmacy such as Wal-Mart, Rite-Aid, K-Mart, or Walgreen's and pay just your copayment. If the pharmacist has difficulty processing the claim, he or she may contact the Pharmacy Help Desk at (877) 205-6308. If you do not have access to a participating pharmacy you may take the prescription to a non-participating pharmacy and submit the pharmacy claim for reimbursement.

REFUNDS

In the event that you have to pay out-of-pocket for a prescription at a participating pharmacy for any medication other than those requiring PPA, you may return to the pharmacy within fourteen (14) days and have the claim processed online for reimbursement of the eligible expenses. However, if your retail pharmacy is unable to resubmit the claim, you may request a Direct Member Reimbursement. **The Prescription Claim Form used for Direct Member Reimbursement can be located in Appendix A.** For Direct Member Reimbursement requests, you will be reimbursed based on your benefits and the applicable copayment will be deducted from your reimbursement. Any forms received with incomplete/missing information may delay payment.

DISPENSE AS WRITTEN (DAW)

State law requires that when there is a generic medication available for a branded medication, the pharmacist should dispense the generic product unless otherwise stated by the physician to dispense as written, or it is requested by the patient. If a member specifically requests a brand name medication, the member will be subject to their 3rd tier copayment and may be responsible for any difference in price between the generic medication and the brand name medication.

PHARMACY SERVICES DEPARTMENT

Bluegrass Family Health has a team of employees that is dedicated to assisting you with any questions or concerns you have regarding your prescription drug benefits. You may contact Pharmacy Services at 877-205-6308 or 859-335-3755.

Due to the nature of some medications, prior plan approval (PPA) may be required for the medication to be covered. Medications that require PPA do so because of their potential for misuse and/or abuse and will require that plan criteria be met. If a medication requires PPA, the ordering physician should contact our Pharmacy Services Department between the hours of 8:00 am and 6:00 pm Eastern Standard Time.

For additional information please see the Bluegrass Family Health Preferred Drug List at www.bgfh.com.

CUSTOMER SERVICE DEPARTMENT

Bluegrass Family Health Customer Service has qualified personnel to assist our members and others with questions or concerns that may arise. Within the Customer Service Department, there is a Provider Claims Unit and a Pharmacy Services Department. If there are any questions concerning the payment of claims, benefits or matters regarding BFH policies or procedures, please contact Customer Service.

As the group administrator, you may contact the Customer Service Department if your Account Service Representative is not available. Agents are available to assist you from 8 am until 6 pm Eastern Standard Time Monday through Friday by calling (859) 269-4475 or (800) 787-2680, or by email at cservice@bgfh.com.

MyBluegrassInfo For Employers

Employers can interact and communicate with BFH with greater ease, simplicity, and efficiency. The service is a paperless solution allowing employers to add and update member information quickly and easily online. MyBluegrassInfo provides employers with the tools to efficiently manage employee information from anywhere at any time, improving their organization's competitive advantage.

In order to access your group information, you must obtain a user ID and password. To do so, simply fill out the **MyBluegrassInfo Registration Form,** found in **Appendix B** and send it to your Account Service Representative. Your Account Service Representative will notify you once your user ID and password have been assigned.

Once you have been assigned a user ID and password, go to www.bgfh.com and select "Employers" from the main menu. Once the Employers page has loaded, select "MyBluegrassInfo" to access your organization's password protected page. There are three tabs located at the top of your Employer home page for you to click on and review information. The information that can be obtained is as follows:

Employer Tab – Review your employer information. Access is also provided to view employees, add new employees, compare benefits and generate keys for open enrollment periods.

Employee Tab – View employee information, print temporary membership cards, request membership cards, enroll employees and dependents, terminate a member, or update member contact information.

Provider Tab – Search for providers included in your network. You can search using different criteria (such as by doctor name or location). Once you have found a provider, you can print directions and a map for their office.

BILLING & ELIGIBILITY

EXPLANATION OF PREMIUM INVOICE

Your group premium invoice (three samples of **Premium Invoices** can be found in **Appendix C)** will be generated approximately the 15th of each month for the following month of coverage. For example, invoices printed on September 15 are for the coverage month of October. Any new hires/changes/terminations that are received prior to the billing cycle will be included on your bill. All new hires/changes/terminations, which are received after the billing run, will not be included until your next month's bill.

For example, an Election/Change Form for a new hire is received on September 22. Since this is after the 15th of the month, the October bills will have already been generated. The new employee will not show up until your November billing. It is very important that you pay as billed and receive any debits/credits on the next bill.

When you receive your premium invoice, you will receive a detail sheet and a remit sheet. The information on your detail sheet will include the following information:

Balance Forward: Total Amount Due, which billed on the previous month's statement, if payment was not received.

Payments Received: This will reflect any payments that were received prior to the bills being generated. Please note, any payments received after the bill generation will not be reflected until the following month's statement.

Subscriber No: Employee's social security number or other unique number.

Name: Employee being covered.

Month: The month, which you are being billed/credited for. If retroactivity occurs, which month the retroactivity is for in this column.

Mem: Number of members covered on the employee's policy.

Plan: Plan option in which the employee is enrolled.

Riders: This column will be blank.

Premium: Amount being billed/credited for the coverage month indicated.

New Charges for Group: Amount the group is being invoiced for the current billing cycle.

Total Amount Due: Total dollar amount the group owes in premium. This amount will include any past due payments as well.

Your remit page is simply a summary of your detail page. Employees are not listed on the remit. A sample of a **Remit** can be found in **Appendix D.** You will see the following information on the remit page:

Premium for Month of: Indicates the month the billing remit was generated for.

Balance Forward: Total Amount Due from the previous month.

Payments: All payments received prior to the bill generation.

Adjustments: All adjustments performed prior to the bill generation.

New Charges: Total premium amount for the current month billing.

Balance Due: Total premium amount due from the group.

Amount Paid: Write in total amount of check being remitted for payment.

Please submit payment and remit by the first day of the coverage month being billed. Questions regarding your premium invoice should be directed to your Billing Representative.

BILLING AND PREMIUM PAYMENT

Bluegrass Family Health will mail premium invoices on or about the 15th of the month **PRIOR** to the month of coverage, as we are a **PREPAID** health plan. The premium payment **is due on or before the first day of the coverage month.** The premium rates listed on the Group Contract Application (if you are billed on a composite or tier basis) or on the Bluegrass Family Health Matrix Rates By Age/Sex sheet (if you are billed on a matrix basis) for coverage selected by the Employer Group multiplied by the number of Members at each applicable rate per month is the billable amount for the coverage month. There may also be included retroactive premium amounts caused by the timing of changes in enrollment and levels. Any balance forward from the previous coverage month will also be immediately due together with the premium for the upcoming coverage month. **(A sample of the Bluegrass Family Health premium invoice can be located in Appendix C.)**

Please **do not** add names to a group invoice remittance advice for an employee whose name does not appear on the invoice without returning a completed Election/Change Form for each new hire. Terminations may be effected on the bill by clearly lining through the employee name and noting the effective date of termination, or by sending

a list of terminations by mail or email. Please include the name, social security number, a reason for termination, and date of termination of each affected employee.

YOUR PREMIUM INVOICE

To reconcile your Premium Invoice, please take the following into consideration:

- Only Election/Change Forms received at our office and processed into the system prior to billing will be reflected on your current billing. Generally, enrollments and terminations received by the 13th of the month will be reflected on the next bill.

- Be sure to pay the **"Total Amount Due"** appearing on each bill.

- Billed premiums deducted this month for employees no longer covered will result in underpayment of your bill since credits are made for terminated employees on the subsequent bill after notice of termination to us.

- **Checks received amounting to less than the "Total Amount Due" may be returned resulting in past due premiums. It may also result in a loss of benefits.**

Upon receipt of your Invoice, verify that all new and terminated employees are correctly indicated and that only eligible employees reflect charges for the current month. Also verify that any other changes in coverage you submitted previously were correctly entered. Remit the total amount due to:

Bluegrass Family Health
P. O. Box 21973
Lexington, KY 40522-1973

EXAMPLES OF PREMIUM INVOICES

Located in Appendix C, you will find three examples of Bluegrass Family Health, Inc. invoices, and one remittance sheet. Invoice #00011111 shows the desirable situation of "Payments Received" being the same amount as the "Balance Forward". This means the group paid the "Total Amount Due" from the previous month's invoice, and the payment was received before this invoice was generated. This example also shows charges for each employee for the upcoming coverage month only with no retroactive debits or credits.

Invoice #00022222 shows a "Balance Forward" from the previous month's invoice, but no "Payments Received" amount, which is not desirable. Of course, we assume the payment was received just after this bill was generated and that this occurs very infrequently. In this case, the next month's invoice will show a "Payment Received" of

twice the normal monthly premium since this group returned to its timely payment habit. Also note on #00022222 there is a retroactive credit for one month's premium for one employee who terminated after the last month's invoice was paid as billed. This shows how the group is credited for a retroactive termination, and Bluegrass Family Health will accept retroactive termination requests for up to 90 days. Invoice #00033333 shows how an Adjustment will appear on the invoice. It also shows a retroactive debit for one month's premium (the January coverage month appearing on the February invoice). Finally, the Remittance sheet for Invoice #00033333 is presented.

ELIGIBILITY

SUBSCRIBER

To be eligible for coverage as a Subscriber, an individual must be an active, permanent employee who lives or works in the Plan's Service Area and meets the eligibility requirements, including any applicable waiting period, as determined by the Group. A copy of **The Bluegrass Family Health Commercial Service Area Map** can be found in **Appendix E.**

DEPENDENT

To be eligible for coverage as a Dependent, an individual must be the lawful spouse or unmarried Dependent child from birth to age 19 or 25 if a full time student (note, age limits may be different for some groups). A "child" means a newborn child, a stepchild, a child legally placed for adoption, a legally adopted child, a child for whom legal guardianship has been awarded, a child eligible to be claimed as a Dependent on the Members' federal income tax return, or a child for whom the Member has a legal obligation under a divorce decree or other court order, including a qualified medical child support order, to provide health care coverage for a child. A Member required by a court or administrative order to provide health coverage for a child must submit proof of such order at the time application for the child is made.

STUDENT

A Dependent child under age 25, or as otherwise specified in the Group's Schedule of Benefits, who is a student in an accredited college, university, trade, or secondary school who is enrolled full-time, will be covered through an entire semester or quarter in which he or she actually attends classes (note, age limit may be different for some groups). Any regularly scheduled break at an accredited college, university, trade, or secondary school following that semester or quarter, is eligible to continue coverage. Twice a year (fall and spring semesters) the plan will require proof of student eligibility. Each Subscriber will receive written correspondence requesting proof of student status. Failure to respond to these notices in a timely fashion will result in termination of the Dependent's coverage. BHF will provide you, the group administrator, with a report of all Dependents who will be terminated due to non-receipt of student status verification. Remember that Dependents losing group coverage have the right to continue coverage

under COBRA or State Continuation provisions. Group size determines which choice is available to them.

Eligibility may continue past the age limit for an unmarried Dependent child who is totally disabled and unable to work to support himself or herself due to physical handicap or mental illness or retardation that began prior to the age limit and is medically certified by a physician. The plan may require proof of the continuing disability from time to time.

ENROLLMENT

In an effort to simplify our processes, we have created an Election/Change Form. This form can be used to enroll a new member, change a current member's information or coverage, or to terminate an employee or Dependent from your group health insurance. Please discard old forms you have for Bluegrass Family Health, as they will not be accepted. Please be sure to use the appropriate form for your size group. **Copies of the Election/Change Forms can be located in Appendix F (for group sizes 2-50) and Appendix G (for group sizes 51+)**. Please ensure that the form is completed and signed by the employee. The only time the employee does not need to sign is when he or she is terminated. Also be sure to include any required documentation. Documentation is required for the following situations: adoption, divorce, legal guardianship, loss of coverage, marriage, and a qualified medical child support order.

If an employee is eligible for coverage on the Group's effective date with the Plan and applies for coverage on or before that effective date, the Member will begin coverage on the Group's effective date. If an employee is eligible for coverage on or after the Group's effective date with the Plan and application is made by the employee within thirty-one (31) days from his or her date of eligibility, then the Member's coverage will start on the date of enrollment. An employee who does not enroll within thirty-one (31) days of his or her date of eligibility must wait until the Group's next open enrollment period to apply for coverage. If application is submitted at the same time the Member initially enrolls for coverage, coverage for Dependents will become effective on the date coverage is effective for the Member. If a Member makes written request for Dependent coverage to add a newly acquired Dependent due to marriage, birth, adoption, or legal guardianship within thirty-one (31) days of these events, the Dependent will be covered from the date of the event. Newly eligible Dependents that are not enrolled within thirty-one (31) days of their initial eligibility may not be added until the Group's next open enrollment period. However, eligible newborns will be covered from the moment of birth for the first thirty-one (31) days. The parent whose birthday comes earlier in the year will determine whose Plan will pay as primary for the first thirty-one (31) days of coverage. Payment of the required premium must be furnished to the Plan that will actually enroll the newborn within thirty-one (31) days after the date of birth in order to have the coverage continue beyond the initial thirty-one (31) day period.

If an employee or eligible Dependent waived coverage under the Group's Contract during the initial period of eligibility and enrolled under the employee's spouse's health

plan, then an employee or Eligible Dependent may enroll under the Group Contract outside of an open enrollment period if any of the following events occurs:

• the spouse's employer terminates its coverage;
• the spouse terminates his or her employment;
• the spouse has a change in position or hours worked and loses coverage; or
• the spouse dies.

OPEN ENROLLMENT

The Open Enrollment process enables an organization to enroll Members in their health plan. This is the primary time each year that any eligible employee can make changes to their existing coverage or enroll as a new member with BFH. The open enrollment period is typically thirty days prior to the group's effective date. Refer to the special enrollment period section of this handbook for information on changing eligibility outside the open enrollment period.

SPECIAL ENROLLMENT PERIOD

"Special Enrollment Period" means a special 31-day enrollment period during which an Employee or Eligible Dependent may enroll in the Plan due to loss of other health care coverage or attaining special eligibility status. One of the following requirements must be met in order to be eligible to enroll during the Special Enrollment Period:

- A Member or his Eligible Dependents were covered under a group health plan at the time this Plan was offered to him and coverage rights were waived, and subsequently his coverage with the other Plan is terminated as a result of loss of eligibility or the employer contributions toward such coverage have now ceased; or

- A Member or his Eligible Dependent were covered under COBRA and now COBRA benefits are exhausted; or

- A Member acquires a Dependent through marriage, birth, adoption or placement of adoption, or legal guardianship of said Dependent.

TERMINATIONS

No Covered Person may be disenrolled unless prior thereto he has been given written notice thirty (30) days in advance of the disenrollment via first-class US mail. Cancellation due to nonpayment of premium will be communicated to the Group at least thirty (30) days prior to the date of cancellation; the Group will then mail promptly to

each Covered Person a copy of the termination notice. For Covered Persons receiving coverage through COBRA or state continuation, Bluegrass Family Health, Inc. will send notification for termination due to nonpayment of premium to the last known address of the Covered Person in the records of Bluegrass Family Health, Inc. If cancellation for nonpayment of premium occurs, the coverage will automatically terminate to the last date through which premium was paid. If the group policy has been cancelled, the Insurer shall notify each group member of his right to conversion within fifteen (15) business days after the end of the 30-day grace period. If the Insurer fails to provide the thirty (30) days' notice required by this section, the coverage shall remain in effect at the existing premium until thirty (30) days after the notice is given or until the effective date of replacement coverage obtained by the insured, whichever occurs first. In the event of cancellation, the Insurer shall return promptly the unearned portion of any premium paid. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation. Notice will be given for termination of coverage for the following:

1. When the Insurer discontinues the plan:
    a. Insurer must provide ninety (90) days notice of discontinuance.
    b. Insurer must offer to each insured with coverage of this type the option to purchase any other type of plan offered by the carrier.
    c. When discontinuing coverage, the Insurer must act without regard to health status.
2. When the Insurer discontinues offering all health benefit plans:
    a. a. Insurer must notify the Commissioner and all who are insured at least 180 days prior to discontinuance.
    b. All health benefit plans must be discontinued and non-renewed.
    c. Insurer cannot re-enter the market for five (5) years.

The Subscriber's coverage will terminate according to the following:

1. The Subscriber is no longer eligible;
2. The Subscriber fails to make any required Premium payment;
3. The Subscriber no longer lives or works in the Service Area;
4. The Subscriber is unable to establish and maintain a reasonable patient-physician relationship with a Primary Care Physician, which includes noncompliance with the prescribed medical treatment plan;
5. The Subscriber commits an act of physical or verbal abuse which poses a threat to Providers or any of the Plan's personnel, subject to written notice being furnished to the Subscriber;
6. The Subscriber commits fraud, material misrepresentation or intentional and abusive noncompliance with the provisions of the Certificate as determined by the Plan; or
7. The Subscriber fails to comply with the provisions of the Certificate and prevents the Plan from providing service to the Member or to other Covered Persons in a reasonable manner.

Coverage for a spouse of the Subscriber will terminate according to the following:

1. The Subscriber's coverage terminates;
2. The spouse is legally divorced from the Subscriber;
3. The spouse is unable to establish and maintain a reasonable patient-physician relationship with a Primary Care Physician;
4. The spouse of the Subscriber commits an act of physical or verbal abuse which poses a threat to Providers or any of the Plan's personnel, subject to written notice being furnished to the Subscriber;
5. The spouse commits fraud, material misrepresentation or intentional and abusive non-compliance with the provisions of the Certificate as determined by the Plan;
6. The spouse no longer lives or works in the Service Area; or
7. The spouse fails to comply with the provisions of the Certificate and prevents the Plan from providing service to the spouse or to other Covered Persons in a reasonable manner.

Coverage for a Dependent child will terminate according to the following:

1. The Subscriber's coverage terminates;
2. The Dependent child marries;
3. A Dependent child has attained the limiting age in the Group Contract or Certificate;
4. A child no longer qualifies as a Dependent;
5. The Dependent child is unable to establish and maintain a reasonable patient-physician relationship with a Primary Care Physician;
6. A Dependent child commits an act of physical or verbal abuse which poses a threat to Providers or any of the Plan's personnel, subject to written notice being furnished to the Member;
7. The Member commits fraud, material misrepresentation or intentional and abusive noncompliance with the provisions of the Certificate as determined by the Plan;
8. The Dependent child, who became disabled prior to the limiting age and whose disability continued beyond such limiting age, is no longer disabled;
9. The Dependent child no longer lives in the Service Area; or
10. The Dependent child fails to comply with the provisions of the Certificate and prevents the Plan from providing service to the Dependent child or to other Covered Persons in a reasonable manner.

ADDRESS CHANGES

Changes to an insured's address may be made on the Election/Change Form or the member may call Bluegrass Family Health Customer Service Department or use MyBluegrassInfo.

IDENTIFICATION CARD

Identification cards are issued to covered persons for identification purposes only and must be presented to Providers when Covered Services are sought. Possession of an identification card does not guarantee a right of benefits under the Certificate of Coverage. To be entitled to benefits, the holder of the identification card must be the Covered Person on whose behalf all applicable premiums have actually been paid. Persons receiving services or other benefits to which they are not entitled will be charged for the services. The identification card is the property of the Plan and its return may be requested at any time. Loss or theft of an identification card should be reported to Customer Service immediately and a new ID card requested.

If any covered person misuses or permits the use of his or her identification card by any other person or otherwise attempts to defraud the plan, the card may be confiscated by Bluegrass Family Health and all rights of the Covered Person with coverage may cease immediately or retroactively to the Covered Person's effective date of coverage, at the sole discretion of Bluegrass Family Health.

COORDINATION OF BENEFITS

The purpose of Coordination of Benefits (COB) is to determine which plan has primary responsibility for payment and which has secondary responsibility when a member has health coverage with more than one insurance plan. 806 KAR 18:030 mandates rules for coordinating benefits. Coordination of benefits prevents duplicate payment for services. **This does not** *increase* out-of-pocket expenses for the member or increase reimbursement.

It is necessary for providers to have information regarding **all** additional sources of insurance covering each member. Participating providers also need to know which insurance is primary. A few general assumptions can be made regarding COB policies:

- BFH is always primary for your employee, the Subscriber.
- If the Subscriber's spouse is employed, his/her employer's insurance plan, if coverage is elected, will be primary.
- If a Subscriber or Member has Medicare, BFH will *usually* be primary because Medicare is almost always secondary to a plan covering active employee's family member. This is determined by the size of the group. However, Medicare as a secondary payer has exceptions. Medicare should be contacted if questions arise.
- *In general*, when children are covered under BFH and another insurance company, the Birthday Rule determines the children's primary insurance will be with the parent whose birthday comes first in the calendar year (Example: Father's birthday is February 16, Mother's birthday is January 12; Mother's insurance is primary).

If you need further clarification of COB, please call our Customer Service Department at (859) 269-4475 or (800) 787-2680.

CLAIMS PROCESSING

All claims are processed based on eligibility on the date of service and covered benefits. The member is not responsible for filing medical claims when using participating providers. Non-participating physicians may ask that the member pay up front and file the claim to their insurance plan. The doctor should provide the appropriate claim form. For all approved and covered services, the member is responsible for the associated deductibles, copays and co-insurance only (depending on choice of Plan). Also, if you go Out-of-Network, you can be billed for anything above the usual, customary and reasonable (UCR) amount. UCR amount is the amount that the Plan determines to be the eligible expense for a service. The eligible expense is determined by the health care service or procedure being performed and the usual amount paid for this procedure in Kentucky.

The most common reason why claims may be delayed include: incomplete claims, claims being reviewed for medical necessity, claims awaiting the arrival of requested documentation and other medical information and claims from non-participating providers.

Claims are processed daily and checks are distributed twice weekly.
If it becomes necessary for a member to submit a claim:

Medical Claims should be mailed to the following address:

Bluegrass Family Health
P.O. Box 22738
Lexington, KY 40522-1970
Attn: Claims Department

Pharmacy Claims should be mailed to the following address:

Bluegrass Family Health
651 Perimeter Drive, Suite 300
Lexington, KY 40517
Attn: Pharmacy Services

If you have any questions regarding a claim, please contact your Account Service Representative at (859) 269-4475 Lexington or (800) 787-2680 or (502) 420-2359 Louisville or (800) 787-2680 . If you have any questions regarding a pharmacy claim, please contact the Pharmacy Services Department at 859-335-3755 or 1-800-699-3542. **In order to check the claims on anyone besides yourself or your own Dependent minor child, you must submit a Use and Disclosure Authorization Form (see Appendix H) signed by the member.**

HEALTHCARE OPERATIONS DEPARTMENT

The Healthcare Operations Department performs medical necessity, benefit coverage and quality reviews on health care related services requested by physicians and other health care providers to ensure the member receives quality health care and the maximum benefits available.

There are specific services and procedures that require prior authorization by the BFH Healthcare Operations Department. All participating providers have a copy of this prior authorization list to which they can refer. It is also available on BFH's website, **www.bgfh.com**. The physician must obtain authorization from BFH's Healthcare Operations Department for services, which require prior approval by calling (877) 449-2884 or (859) 335-3737. The member is responsible for verifying if covered services have been prior-authorized by the Plan for HMO, POS or PPO plans.

CHIROPRACTIC SERVICES

Bluegrass Family Health has contracted with ACN Group, Inc., a health care organization that specializes in the delivery of chiropractic services nationwide, to provide authorization of chiropractic care. **Chiropractic services do not require referral, but do require prior authorization. For specific questions about chiropractic services, please call (800) 873-4575.**

MENTAL HEALTH AND SUBSTANCE ABUSE

If the member and their physician determine these services are needed, the member or doctor may contact Saint Joseph Behavioral Medicine Network at (800) 455-5579 or (859) 224-2022, directly to obtain **prior authorization** for needed care. Treatment needs will be assessed and the necessary services will be arranged to be provided by the most appropriate mental health professionals.

CARE CONTINUUM

Bluegrass Family Health has a network management arrangement with Care Continuum, a SpectraCare Company, for home health and home infusion services. This arrangement provides statewide home health and infusion coverage through Care Continuum's comprehensive provider network. Care Continuum is responsible for prior authorizations and continued management of the utilization of home care services. The

ordering physician must contact Care Continuum to initiate an authorization. Care Continuum can be reached by calling (502) 339-8088 or (877) 700-3482.

A listing of Care Continuum's comprehensive home health provider network may be viewed on their website at www.carecontinuum.com. To access the network, click on "Network Management" and follow the directions.

*NURSE*FIRST

*Nurse***First** is a telephone triage service staffed by Registered Nurses. It is available 24 hours a day, seven days a week to answer member health care concerns and questions. *Nurse***First** is a service exclusive to BFH members. The confidential toll free number is 1-800-391-6861.

CASE MANAGEMENT

Case Management is a mechanism to facilitate patient-centered coordination and management of care throughout the health care continuum. This member/caregiver assistance approach focuses on coordinating services to promote quality, cost-effective care through benefit management, community resources and Provider involvement in potentially catastrophic cases. It is designed to empower members by assisting them with the understanding of their disease or disability. This process helps to ensure that appropriate care is provided and to maintain communication between providers. Case Management is utilized prior to, during and following any care delivered by the provider network. Case Management is not for everyone. If you feel that you have a member who could benefit from our case management services, please have them or their Provider contact us at (859) 335-3737 or toll free at (877) 449-2884.

POPULATION HEALTH MANAGEMENT

Bluegrass Family Health believes that the use of disease management programs will help improve the care of its members with common chronic illnesses. The process identifies high incidence/high cost disorders, disorders with wide variability in diagnostic and treatment approaches, under diagnosis, and the need to track and improve member outcomes.

Bluegrass Family Health utilizes the United Resource Network (URN) for members who may require transplant services. The URN selects facilities based on the transplant team's experience, expertise and outcomes. Each type of transplant is individually reviewed for inclusion in the URN network.

The regional facilities that are approved include Jewish Hospital in Louisville, Barnes Jewish in St. Louis, St. Louis Children's Hospital in St. Louis, and Children's Hospital in Cincinnati. Some facilities are approved for some transplants and not others.

For Most Select Transplant Network, InterLink Transplant Network and the University of Kentucky are also available. Please contact the Transplant Case Manager at Bluegrass Family Health with questions at (800) 787-2680, extension 5356 and extension 5351.

QUALITY MANAGEMENT

The Quality Management Program is designed to objectively and systematically monitor and evaluate the quality and appropriateness of care and service provided to members. The Quality Outcomes Committee and the Board of Directors direct the program.

HEDIS®

Each year Bluegrass Family Health selects and examines a sample of medical records to measure quality. These quality studies, called HEDIS®, are part of a nationally recognized quality improvement initiative. HEDIS® is used by the Center for Medicare & Medicaid Services, the National Committee for Quality Assurance, and several states for monitoring the performance of managed care organizations. Bluegrass Family Health is pleased to participate in these studies during the months of March, April, and May and appreciates the support of our provider community in continuously improving our scores.

DISEASE MANAGEMENT PROGRAMS

DIABETES MANAGEMENT PROGRAM – "TAKE A1CONTROL"

Take A1Control is the Diabetes Disease Management Program. Members that participate in Take A1Control receive individualized attention, interaction, and coordination of care by a Registered Nurse. Take A1Control is open to members with all types of diabetes. Program participation is voluntary and at no cost. Members can enroll in the program through a physician or self-referral. Upon referral the Diabetes Program Manager will contact the member. Take A1Control entails collaboration with physicians, pharmacists, nurses, community resources, and the Kentucky Diabetes Network. The goal of Take A1Control is to assist members to be active in self-management of their disease. By doing so, catastrophic complications such as blindness, heart disease, nerve damage, kidney failure, and amputation can be prevented.

Educational materials, access to e-health programs, and updates on diabetes treatments and technologies will be provided to the member. In addition, the member will receive reminders when it is time for physician checkups for diabetes health-related management, such as blood work, dilated eye exams, foot inspections, and flu shots. All checkup recommendations are based on the American Diabetes Association's Clinical Practice Recommendations.

Bluegrass Family Health also has a program that is able to provide free blood glucose monitors to members. Members will have the choice of three vendors from which to choose. We have selected these vendors based on input received from our providers, as well as their high quality and ease of use:

> Ascensia DEX2®, ELITE, ELITE XL, and BREEZE Diabetes Care System through Bayer Diagnostics
> Phone (877) 229-3777
> Fax (800) 876-2243
>
> FreeStyle Blood Glucose Monitoring System through Therasense
> Fax (800) 677-4100

BFH Members are not required to use only these products. The above listed Accu-Chek meters and Ascensia DEX2 and ELITE meters are available to members at participating pharmacies at their first tier copay. Members may purchase any other meter of their choice and submit those receipts to BFH Claims Department for reimbursement. Members will be reimbursed for the meter less their pharmacy second tier copay.

RMS – END-STAGE RENAL DISEASE PROGRAM

RMS is a disease management program designed to provide optimum care for BFH members diagnosed with End-Stage Renal Disease (ESRD) who currently receive dialysis services. The ESRD care management program is designed to both improve and simplify care for the ESRD member. A Health Service Coordinator (HSC) who is a registered Nurse coordinates care, provides health education, and works closely with the member. The member has 24-hour access to the Health Service Coordinator (HSC) for any urgent issues related to their health care.

CARDIOVASCULAR DISEASE MANAGEMENT PROGRAM – HEART SENSE

Heart Sense is a cardiovascular disease management program. It was designed to focus on two types of members: those that have risk factors which lead to coronary heart disease and those who are actively battling heart disease at different levels of severity. The Heart Sense program is coordinated by a Registered Nurse with experience in cardiovascular disease. Heart Sense provides individualized attention and assistance in stabilizing members with heart problems and decreasing or modifying the risk factors of members that are in danger of developing heart disease.

Members are taught to manage their heart disease at home by incorporating additional simple steps in their routines of daily living. Heart Sense has specific programs established to decrease or modify the following heart disease risk factors:

Smoking, Hypertension, Hypercholesterolemia and Obesity.

The goal of the Heart Sense program is to quantitatively show a decrease in the risk factors that are proven to lead to heart disease and an increase in the ability of our members to more effectively manage their heart disease through education, guidance and appropriate intervention of program's coordinator.

"SPECIAL DELIVERY" MATERNITY PROGRAM

"Special Delivery" maternity program is designed to offer guidance and information to promote healthy outcomes for both mother and baby. It is not meant to be a substitute for physician care and information, but a compliment to the provider's expertise.

The nurses in BFH's Population Health Management Department manage the "Special Delivery" maternity program. The book, *Planning your Pregnancy and Birth*, developed by the American College of Obstetrics and Gynecology, will be given to all of our identified pregnant members. The nurses will evaluate and assess the member's potential for high-risk pregnancy utilizing an assessment tool throughout the member's pregnancy. Those members identified as high-risk will be referred to the Obstetrical Case Manager to follow the member through her pregnancy.

The initiation of the program will begin at the first notification from either the member's provider or the member herself. This will be accomplished either via phone or fax. A "Special Delivery" packet including the book *Planning Your Pregnancy and Birth* will be mailed. Those members choosing to enroll in the program will return their completed prenatal assessment form for analysis by the OB Nurse Case Manager. Those members with identified risk factors will be enrolled into the High Risk OB program for closer telephonic monitoring/ care coordination throughout their pregnancy. The OB Nurse Case Manager is also available to answer questions for all of our maternity members enrolled in the program.

PROVIDER NETWORK AND SERVICE AREA

The service area is a geographic area in which Bluegrass Family Health is licensed to do business. A copy of **The Bluegrass Family Health Commercial Service Area Map** can be found in **Appendix E.** In order to be eligible to enroll as a member with BFH, the employee must live or work in the service area.

Participating Providers include physicians, hospitals and other types of professional health care providers who have contracted with BFH to provide services or supplies to our Members. **It is the responsibility of the Member to use only participating providers in order to receive in-network benefits.** Every effort is made to assure the accuracy of the Provider Directory, however changes may occur on a daily basis, so there may be providers who have been added or deleted from the network after the directory was printed. For the most accurate and up-to-date provider listing, please visit our website at www.bgfh.com or call Customer Service at (859) 335-3705 or (877) 449-7378.

NON-PARTICIPATING PROVIDERS

There are many reasons why a provider may not be participating with Bluegrass Family Health. If the physician, you or your employee is currently utilizing is non-participating provider with BFH, the provider may contact the BFH Provider Relations Department at (859) 269-4475 or (800) 787-2680 to inquire about the possibility of contracting with BFH. For HMO benefit plans, it is very important that the member refer to the BFH Provider Directory for the list of participating physicians. The member may wish to verify with BFH's Customer Service Department if a provider participates. Every effort is made to assure the accuracy of the Provider Directory, however changes may occur on a daily basis, so there may be providers who have been added or deleted from the network after the directory was printed. For the most accurate and up-to-date provider listing, please visit our website at www.bgfh.com or call Customer Service at (859) 335-3705 or (877) 449-7378. In some instances there may be a request that a non-participating provider see a member. The provider must contact the BFH Healthcare Operations Department in order to determine if this will be approved. Claims for non-participating providers will be denied unless approved in advance by BFH's Healthcare Operations Department.

MEMBERS' RIGHTS & RESPONSIBILITIES

- Members have a right to receive information about the managed care organization, its services, its practitioners and providers, and members' rights and responsibilities.
- Members have a right to be treated with respect and recognition of their dignity and right to privacy.
- Members have a right to participate with practitioners in decision-making regarding their health care.
- Members have a right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Members have a right to voice complaints or appeals about the managed care organization or the care provided.
- Members have a right to make recommendations regarding the organization's members' rights and responsibilities policies.
- Members have a responsibility to provide, to the extent possible, information that the managed care organization and its practitioners and providers need in order to care for them.
- Members have a responsibility to follow the plans and instructions for care that they have agreed on with their practitioners.
- Members have a responsibility to understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible.

NOTICE OF INFORMATION PRACTICES

Due to the requirements of the federal laws known as the Gramm-Leach-Bliley Act and the privacy requirements of the Health Insurance Portability and Accountability Act (HIPAA), which became effective April 14, 2003, Bluegrass Family Health must provide members with information on our privacy and confidentiality practices. The purpose of this information practices notice is to provide a notice to Covered Persons regarding the Plan's standards for the collection, use, and disclosure of information gathered in connection with the plan's business activities. A copy of the **Notice of Privacy Practices** can be found in **Appendix I.**

The plan may collect personal information about a Covered Person from persons or entities other than the Covered Person. The plan may disclose Covered Person's information to persons or entities outside the Plan without the Covered Person's authorization in certain circumstances.

Bluegrass Family Health does not utilize non-public personal health information for any purposes outside the scope of the permitted uses under 806 KAR 3:220 and under the provisions of HIPAA without a signed authorization from the Covered Person. The authorization forms are provided by Bluegrass Family Health in accordance with the provisions of the applicable laws. A copy of the **Use and Disclosure Authorization Form** can be found in **Appendix H**.

Permitted Disclosures include, but are not limited to: claims processing, case management, and quality improvement purposes. In all permitted uses of this information, Bluegrass Family Health stresses the confidentiality of the information.

Bluegrass Family Health is required by law to retain certain records for individuals who are no longer participating with our health plan. In order to maintain this information, as well as that of our current customers, we maintain physical, electronic, and procedural safeguards.

Bluegrass Family Health does not provide access to information to any covered member regarding a spouse or dependant over the age of eighteen (18) unless they have completed a **Use and Disclosure Authorization Form**, found in **Appendix H**.

MEMBER INQUIRY, COMPLAINT & APPEALS PROCESS

Bluegrass Family Health provides a thorough process to address Covered Person complaints and appeals. These administrative remedies must be exhausted before legal remedies are sought.

INQUIRIES AND COMPLAINTS

If you have an inquiry or complaint regarding your benefits or claims, you may contact a Customer Service Representative at (859) 269-4475 or (800) 787-2680. We will respond to your complaint within fifteen (15) calendar days. An example of a complaint would be "I have trouble getting into my doctor's office in a timely manner." We track and trend all Covered Person complaints for quality improvement purposes.

INTERNAL APPEALS

A Covered Person, authorized person or Provider acting on behalf of the Covered Person may initiate an internal appeal. An appeal is a request for review of an Adverse Determination or a coverage denial as defined below. An internal appeal may also be initiated if an insurer or its designee fails to make a utilization review determination and provide written notice within the timeframes as specified in KRS 304.17A-607.

"**Adverse Determination**" means a determination by an insurer or its designee that the health care services furnished or proposed to be furnished to a Covered Person are:

1. Not medically necessary, as determined by the insurer, or its designee or experimental or investigational, as determined by the insurer, or its designee; and
2. Benefit coverage is therefore denied, reduced, or terminated.

Adverse determination does not mean a determination by an insurer or its designee that the health care services furnished or proposed to be furnished to a Covered Person are specifically limited or excluded in the Covered Person's health benefit plan.

"**Coverage Denial**" means an insurer's determination that a service, treatment, drug, or device is specifically limited or excluded under the Covered Person's health benefit plan.

A request for an internal appeal must be submitted within sixty (60) calendar days of notification of denial. To initiate an internal appeal, please forward the following information to the attention of the Appeals Coordinator, Bluegrass Family Health, 651 Perimeter Drive, Suite 300, Lexington, Kentucky 40517:

- The initial denial letter
- The number of claims in question
- The date(s) of service
- A summary of any previous communication you have had with Bluegrass Family Health regarding this denial
- Any additional pertinent medical information

A Kentucky licensed Physician who did not participate in the initial review and denial will review internal appeals of Adverse Determinations. The covered person, authorized person, or Provider may request a board eligible or certified Physician in the appropriate specialty or subspecialty area to conduct the internal appeal relating to an Adverse Determination.

The Covered Person, authorized person, or Provider acting on behalf of the Covered Person will be notified of the internal appeal decision within thirty (30) calendar days of receipt of the internal appeal request.

EXPEDITED INTERNAL APPEALS

An expedited internal appeal process is available if the Covered Person is hospitalized or, in the opinion of the treating provider, a review under a standard time frame could, in the absence of immediate medical attention; result in any of the following:

a. Placing the health of the Covered Person or, with respect to a pregnant woman, the health of the Covered Person or the unborn child in serious jeopardy;
b. Serious impairment to bodily functions; or
c. Serious dysfunction of a bodily organ or part.

In the case of an expedited appeal the insurer or its designee shall render a decision not later than three (3) business days after the receipt of the request for an expedited internal appeal. An expedited appeal may be requested orally and followed up by an abbreviated written request by contacting Bluegrass Family Health at (859) 269-4475 or (800) 787-2680 and requesting the Appeals Coordinator, or in writing by sending the request to the Appeals Coordinator, Bluegrass Family Health, 651 Perimeter Drive, Suite 300, Lexington, Kentucky 40517.

Any additional pertinent information may be submitted for consideration during the internal appeal process. Once the internal appeal process has been completed, but prior to the initiation of the external review process, new clinical information regarding the Covered Person's internal appeal shall be provided to the insurer. The insurer shall then have five (5) business days from the date of receipt of the new information to render a decision based on the new information. The sixty (60) calendar day timeframe to initiate an external review of an Adverse Determination shall not begin until the determination on the new information has been rendered.

EXTERNAL REVIEW OF COVERAGE DENIALS

If the Covered Person, authorized person, or Provider is dissatisfied with the internal appeal decision or if the internal appeal decision is not rendered within the required time frame, the Covered Person may request a review of a "coverage denial" by the Kentucky Department of Insurance, Division of Health Insurance Policy and Managed Care, P.O. Box 517, Frankfort, Kentucky 40602.

The Kentucky Department of Insurance may uphold the Plan's decision, or direct the Plan to cover the service, or afford the Covered Person the opportunity for an external review by independent review entity (IRE) if a medical issue requires resolution.

EXTERNAL REVIEW OF ADVERSE DETERMINATIONS

If the Covered Person is dissatisfied with the internal appeal decision or if the internal appeal decision is not rendered within the required time frame or the insurer and Covered Person agree to waive the internal appeal process, the Covered Person may request an external review of an "Adverse Determination" or Coverage Denial which requires resolution of a medical issue, by an independent review entity (IRE) certified by the Kentucky Department of Insurance.

The external review process can be initiated by a Covered Person, authorized person, or provider acting on behalf of and with the consent of the Covered Person within 60 calendar days after exhausting the internal appeal process, if the following conditions are met:

1. The insurer, its designee, or agent has rendered an Adverse Determination;
2. The Covered Person has completed the insurer's internal appeal process, or the insurer has failed to make a timely determination or notification as set forth in KRS 304.17A-619(2). The insurer and the Covered Person may however, jointly agree to waive the internal appeal requirement;
3. The Covered Person was eligible on the date of service or, if a prospective denial, the Covered Person was enrolled and eligible to receive covered benefits under the health benefit plan on the date the proposed service was requested; and
4. The entire course of treatment or service will cost the Covered Person at least $100 if the Covered Person had no insurance.

An external review of an "Adverse Determination" shall not be afforded if:

1. The subject of the Covered Person's adverse determination has previously gone through the external review process and the independent review entity found in favor of the insurer; and
2. No relevant new clinical information has been submitted to the insurer since the independent review entity found in favor of the insurer.

If a dispute arises between an insurer and a Covered Person regarding the Covered Person's right to an external review, the Covered Person may file a complaint with the Kentucky Department of Insurance at the address listed above. The Department shall render a decision within five (5) days of receipt of the complaint.

The insurer will be responsible for the cost of the external review. The Covered Person will, however, be responsible for a $25 filing fee to be paid to the IRE, which may be waived in case of financial hardship, or refunded if the IRE finds in favor of the Covered Person. The insurer will assign external reviews to IREs on a rotating basis such that the insurer does not utilize the same IRE for two consecutive reviews.

Requests for external review shall be submitted to External Review, Appeals Department, Bluegrass Family Health, 651 Perimeter Drive, Suite 300, Lexington, Kentucky 40517. If you have questions regarding the external review process please contact Customer Service at (859) 269-4475 or (800) 787-2680 and ask to speak with the Appeals Coordinator.

As part of the request, the Covered Person shall provide to the insurer a consent authorizing the IRE to obtain all necessary medical records from both the insurer and any provider utilized for review purposes regarding the decision to deny, limit, reduce, or terminate coverage. All medical records involved in the external review process shall be deemed confidential and shall not be subject to KRS 61.805-61.850 and KRS 61.870-61.884.

The IRE must render a determination within twenty-one (21) calendar days of receipt of the request for external review. An extension of up to fourteen (14) calendar days may be allowed if the Covered Person and the insurer are in agreement.

EXPEDITED EXTERNAL REVIEW

An expedited external review process is available if the Covered Person is hospitalized or, in the opinion of the treating provider, a review under a standard time frame could, in the absence of immediate medical attention; result in any of the following:

a. Placing the health of the Covered Person or, with respect to a pregnant woman, the health of the Covered Person or her unborn child in serious jeopardy;
b. Serious impairment to bodily functions; or
c. Serious dysfunction of a bodily organ or part.

In the case of an expedited external review the IRE shall render a decision within twenty-four (24) hours from receipt of all information required from the insurer. An extension of up to twenty-four (24) hours may be allowed if the Covered Person and Bluegrass Family Health agree. An expedited external review may be requested orally and followed up by an abbreviated written request by contacting Customer Service at (859) 269-4475 or (800) 787-2680 and requesting the Appeals Coordinator, or in writing by sending the request to External Review, Appeals Department, Bluegrass Family Health, 651 Perimeter Drive, Suite 300, Lexington, Kentucky 40517.

IMPORTANT REMINDERS

- Eligible Subscribers must be full-time active employees.
- Employees applying for coverage with Bluegrass Family Health MUST live or work in the Service Area.
- Election/Change Forms must be signed by the employee unless terminating.
- Necessary documents such as birth and marriage certificates, full time student verification, divorce papers, etc. must accompany the enrollment forms when applicable.
- Bluegrass Family Health must receive a "completed" Election/Change Form.
- Qualifying events are: marriage, newborn, divorce, death, loss of coverage and adoption. If Bluegrass Family Health does not receive application within thirty-one (31) days of a qualifying event, the member/dependent cannot be enrolled until the next open enrollment, when all employees can make changes.
- It is important to remind Bluegrass Family Health members with your group that they carry their ID cards with them at all times.
- Contact your Account Service Representative should you need to discuss any concerns or problems that your employees may be experiencing. Please call your Account Service Representative to request additional material for new hires, etc.
- You may not voluntarily drop coverage on yourself or dependents during the plan year without a qualifying event.

Members can access coverage information 24 hours a day at MyBluegrassInfo through our website: www.bgfh.com.

APPENDIX A

PRESCRIPTION CLAIM FORM

Bluegrass Family Health

Prescription Claim Form

Instructions for use: Please use a separate claim form for each member requesting a reimbursement. Attach all pharmacy receipts to the claim form. Mail to: BFH 651 Perimeter Drive, Suite 300, Lexington, Ky. 40517 Attn: Pharmacy. All claims will be reviewed upon receipt. Process time is 6-8 weeks. The following information must be provided in order for a claim to be considered for reimbursement by BFH:

Primary Cardholder's Information

Name of Insured: ______________________________

ID Number: ______________________________

Insured's Address: ______________________________
(Street Address

____
(City) **(State)** **(Zip)**

Insured's Telephone number: (______)______________________________

Other insurance/policy number______________________________

Prescription Information

Name on Prescription: ______________________________

Date of Birth: ______________________________

Relationship to insured if not insured: ______________________________

***Please include Original receipt from dispensing Pharmacy with the following information:**

- **Name of the medication**
- **National Drug code (NDC Number)**
- **NABP number of the dispensing pharmacy (National Pharmacy Code)**
- **Date of service**
- **Quantity Dispensed/Days supply**
- **Amount of purchase**

The completion of this form is not a guarantee of payment. Requests for reimbursement are subject to all Plan rules and requirements. Before mailing your request, please make copies for your records.

APPENDIX B

MyBluegrassInfo
REGISTRATION FORM

MyBluegrassInfo Employer Access Request Form

Please fax to the Bluegrass Family Marketing Dept. at (859) 335-3750.

By signing this document, I agree to the following terms and conditions of use: (1) I agree that the person completing this form is the person whose signature appears below** (2) I understand that the information I receive through the use of the MyBluegrassInfo product is confidential and shall not be disclosed to anyone other than the authorized user (3) I understand and agree to maintain the confidentiality of my account information including password (4) I understand and agree that I must notify Bluegrass Family Health of any significant changes in my user status, i.e. I leave my current employment, I change insurers, etc.; and (5) I understand and agree that any failure to maintain the confidentiality of my user information and password and/or the information made available to me through the MyBluegrassInfo product will subject me to civil and criminal liability. Bluegrass Family Health may revoke access to this module at any time if we believe that it is being misused.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the use of the MyBluegrassInfo product and consent to the conditions herein. In addition, I agree to the instructions outlined herein, as well as any other requirements that Bluegrass Family Health may impose.

Employer Group Name:

Employee Name: Employee Email Address:

Employee Signature: Phone Number: Date:

Please keep a copy of this form for your own records.

***KRS § 516.030* states that a person is guilty of forgery in the second degree when, with intent to defraud, deceive or injure another, he falsely makes, completes or alters a written instrument. Forgery in the second degree is a Class D felony and can be punishable by fine of no less than $1,000 and up to $10,000 AND imprisonment up to five years.

KRS § 516.090(1)(b) states that a person is guilty of possession of a forgery device when he make or possesses with knowledge of its character any device, apparatus, equipment or article capable of or adaptable to use in forging written instruments with intent to use it himself or aid or permit another to use it for purposes of forgery. Possession of a forgery device is a Class D felony and can be punishable by fine of no less than $1,000 up to $10,000 AND imprisonment up to five years.

APPENDIX C

PREMIUM INVOICE SAMPLES

Bluegrass **Family Health**

01/15/2003
Page 1

I N V O I C E
#00011111

Group: 414435
Acme, Inc.
123 ABC Street
Anytown, Kentucky 49494

Balance Forward 1500.00
Payments Received 1500.00

SubscriberNo	Name	Month	Mem	Cov	Plan	Riders	
123456789	Doe, Johnny	02/03	1	1	N0053-09		250.00
234567890	Johnson, Joseph	02/03	2	2	N0053-09		525.00
345678901	Smith, Susan	02/03	5	4	N0053-09		725.00

New Charges For Group 1500.00

Total Amount Due: 1500.00

Bluegrass **Family Health**

01/15/2003
Page 1

I N V O I C E
#00022222

Group: 414435
Acme, Inc.
123 ABC Street
Anytown, Kentucky 49494

Balance Forward 1500.00
Payments Received .00

SubscriberNo	Name	Month	Mem	Cov	Plan	Riders	
123456789	Doe, Johnny	01/03	0	0	N0053-09		-250.00
234567890	Johnson, Joseph	02/03	2	2	N0053-09		525.00
345678901	Smith, Susan	02/03	5	4	N0053-09		725.00

New Charges For Group 1000.00

Total Amount Due: 2500.00

P O BOX 21970 •LEXINGTON KENTUCKY 40522-1970 • (859) 269-4475 • (800) 787-2680

Bluegrass Family Health

01/15/2003
Page 1

I N V O I C E
#00033333

Group: 414435
Acme, Inc.
123 ABC Street
Anytown, Kentucky 49494

Balance Forward 2750.00
Payments Received 2750.00

Adjustments:
01/10/03 Compliance Adjustment for Age Band Override -132.76

SubscriberNo	Name	Month	Mem	Cov	Plan	Riders	
123456789	Doe, Johnny	02/03	2	2	N0053-09		525.00
234567890	Johnson, Joseph	02/03	5	4	N0053-09		725.00
345678901	Smith, Susan	02/03	4	3	N0053-09		650.00
345678901	Smith, Susan	01/03	4	3	N0053-09		650.00

New Charges For Group 2550.00

Total Amount Due: 2417.24

APPENDIX D

REMIT

Bluegrass **Family Health**

I N V O I C E
#00141540

Group: 414435
Acme, Inc.
123 ABC Street
Anytown, Kentucky 49494

PREMIUM FOR THE MONTH OF JANUARY 2003	
Balance Forward:	$2750.00
Payments:	$2750.00
Adjustments:	$-132.76
New Charges:	$2550.00
Total Amount Due:	$2417.24
Amount Paid:	$ ____________

Payment is due on the first day of the coverage month referenced above. Please remit your payment in full along with this remittance sheet.

IMPORTANT NOTICE: TERMINATION OF GROUP HEALTH COVERAGE
IF BLUEGRASS FAMILY HEALTH DOES NOT RECEIVE THE GROUP PREMIUM PAYMENT WITHIN THE 30 DAY GRACE PERIOD FOLLOWING THE PREMIUM PAYMENT DUE DATE, BLUEGRASS FAMILY HEALTH WILL TERMINATE THE GROUP HEALTH COVERAGE EFFECTIVE ON THE LAST DATE THROUGH WHICH FULL PREMIUMS WERE PAID. THIS NOTICE SERVES AS THE 30-DAY NOTICE OF TERMINATION AS REQUIRED BY LAW.

If this bill reflects an outstanding premium balance for the prior month's bill, Bluegrass Family Health's issuance of this invoice does not waive Bluegrass Family Health's contractual right to automatically terminate your coverage for failure to timely pay premiums.

APPENDIX E

COMMERCIAL SERVICE AREA MAP

Bluegrass Family Health

2004 COMMERCIAL MARKETING AREA

BOONE
KEN-TON
CAMP-BELL
GALLA-TIN
CARROLL
TRIMBLE
GRANT
PENDLE-TON
BRACKEN
MASON
LEWIS
GREENUP
BOYD
CARTER
ELLIOTT
LAWRENCE
ROBERT-SON
OWEN
HENRY
OLDHAM
HARRISON
FLEMING
NICHOLAS
SCOTT
FRANKLIN
SHELBY
JEFFERSON
BOURBON
ROWAN
BATH
WOOD-FORD
FAYETTE
MONT-GOMERY
CLARK
SPENCER
ANDERSON
MENIFEE
MORGAN
JOHNSON
MARTIN
BULLITT
MEADE
HAN-COCK
HENDERSON
DAVIESS
UNION
BRECKINRIDGE
HARDIN
NELSON
JESS-AMINE
POWELL
WOLFE
MAGOFFIN
MERCER
WASHINGTON
MADISON
ESTILL
LEE
FLOYD
PIKE
GAR-RARD
BOYLE
MARION
BREATHITT
LARUE
WEBSTER
McLEAN
OHIO
GRAYSON
LINCOLN
JACKSON
OWSLEY
KNOTT
CRITTENDEN
HOPKINS
HART
TAYLOR
CASEY
ROCKCASTLE
PERRY
LIVING-STON
MUHLENBERG
BUTLER
EDMONSON
GREEN
CLAY
LESLIE
LETCHER
CALDWELL
LAUREL
PULASKI
BALLARD
McCRACKEN
LYON
ADAIR
WARREN
BARREN
METCALFE
RUSSELL
KNOX
HARLAN
CARLISLE
MARSHALL
TRIGG
CHRISTIAN
TODD
LOGAN
CUMBER-LAND
WAYNE
WHITLEY
BELL
GRAVES
SIMPSON
ALLEN
MONROE
CLINTON
McCREARY
HICKMAN
CALLOWAY
FULTON

APPENDIX F

ELECTION/CHANGE FORM (2-50)

Bluegrass Family Health

Mail or Fax to - Attn: Eligibility
651 Perimeter Drive, Ste 300 — Phone (859) 269-4475
Lexington, KY 40517 — Fax (859) 335-3721

ELECTION/CHANGE FORM GROUP SIZE 2-50

To be completed by employer

Group #	Sub Group #
Group Name	
Hire Date	
Effective Date of Enrollment/Change	

Social Security No./Member No.	Employee's Last Name	First Name, MI	Gender	Date of Birth (MM/DD/YY)

Street Address	City	State	Zip	County

Home Phone | Work Phone | Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Type of Contract ☐ Employee ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Family | Retired ☐ Yes ☐ No | Disabled ☐ Yes ☐ No | Email Address

☐ **ENROLL**
___Open Enrollment
___New Hire
___Rehire
*___Loss of other coverage
___COBRA/Continuation
original start date:___________
number of months eligible (circle one)
18 29 36

☐ **CANCEL**
___Open Enrollment
___Termination of Employment
*___Qualifying Event
___Term COBRA/Continuation
___Other:______________

☐ **CHANGE**

Add Dependent(s)
___Open Enrollment
___Newborn
*___Marriage
*___Loss of other coverage
*___Adoption
___Other:__________

Drop Dependent(s)
___Open Enrollment
*___Divorce
*___Obtained other coverage
___Age Limit Exceeded
___Other:__________

General
___Name
___Address
___Telephone
___Other:__________

***Please attach supporting documentation**

Persons to be Covered—List your spouse and/or eligible dependents to be covered. Use separate form for additional dependents.
FOR DEPENDENTS 19 AND OVER, PLEASE PROVIDE PROOF OF FULL TIME STUDENT STATUS.

Add (A)	Drop (D)	Relationship of Eligible Dependents	Full Name (Last, First, MI)	Date of Birth MM/DD/YY	Gender (M) (F)	Social Security No./Member No.
A	D	Spouse				
A	D	Child 1				
A	D	Child 2				
A	D	Child 3				

Prior Coverage (This section must be completed)
Have you or any dependents been covered by another health insurance plan at any time during the last 12 months? ☐ Yes ☐ No
a. Name of Insured__________________ Name of Prior Employer Providing Coverage__________________
b. Type of Contract: ☐ Employee ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Family
c. Insurance Company Name__________________ Effective Date__________ Termination Date__________

Other Health Coverage (This section must be completed)
Is your spouse employed? ☐ Yes ☐ No Employer__________________
Will you or any other family member be covered through another health insurance plan? ☐ Yes ☐ No
If YES, please list names of covered individuals.__________________
Insurance Company Name__________________Policy Number__________Effective Date__________Phone Number__________
Does this include a prescription benefit? ☐ Yes ☐ No

Terms and Conditions

A. I understand that I am responsible for promptly reporting to my employer any changes in my marital status, my number of eligible dependents or change in my residence.
B. I hereby authorize any hospital, physician, surgeon, or pharmacist to release any information requested by Bluegrass Family Health, Inc. with respect to any claim of the delivery of medical care on behalf of myself or a covered dependent. A photocopy of this authorization will serve the same as the original. This authorization is not the same as a HIPAA Authorization.
C. I agree that any medical benefits payable on my behalf under my employer's Group Medical Benefits Plan may be paid directly to the provider of care.
D. I understand and agree that no benefits shall take effect until this enrollment/change form is **approved** by Bluegrass Family Health Inc. Upon such acceptance, Bluegrass Family Health, Inc. shall as soon as possible, issue an identification card(s) to me.
E. I authorize my employer to make the necessary deductions from my pay or any disability or retirement annuity benefits to which I may be entitled under any group plan sponsored by my employer while I am enrolled in Bluegrass Family Health, Inc. until this authorization is revoked by me in writing.
F. I understand that I must be actively at work on the effective date of coverage or the effective date will be on the date I return to work, unless my absence is due to a medical condition.

Employee Signature__________________ Date__________

APPENDIX G

ELECTION/CHANGE FORM (51+)

Bluegrass Family Health

Mail or Fax to - Attn: Eligibility
651 Perimeter Drive, Ste 300
Lexington, KY 40517

Phone (859) 269-4475
Fax (859) 335-3721

ELECTION/CHANGE FORM GROUP SIZE 51+

To be completed by employer

Group #	Sub Group #
Group Name	
Hire Date	Effective Date
Plan Option	

Social Security No./Member No.	Employee's Last Name	First Name, MI	Gender	Date of Birth (MM/DD/YY)

Street Address	City	State	Zip	County

Home Phone | Work Phone | Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Type of Contract ☐ Employee ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Family | Retired ☐ Yes ☐ No | Disabled ☐ Yes ☐ No | Email Address

☐ **ENROLL**
___Open Enrollment
___New Hire
___Rehire
*___Loss of other coverage
___COBRA
original start date:______________
number of months eligible (circle one)
18 29 36

☐ **CANCEL**
___Open Enrollment
___Termination of Employment
*___Qualifying Event
___Term COBRA
___Other:______________________

☐ **CHANGE**

Add Dependent(s)
___Open Enrollment
___Newborn
*___Marriage
*___Loss of other coverage
*___Adoption
___Other:______________

Drop Dependent(s)
___Open Enrollment
*___Divorce
*___Obtained other coverage
___Age Limit Exceeded
___Other:______________

General
___Name
___Address
___Telephone
___Other:______________

*Please attach supporting documentation

Persons to be Covered—List your spouse and/or eligible dependents to be covered. Use separate form for additional dependents.
FOR DEPENDENTS 19 AND OVER, PLEASE PROVIDE PROOF OF FULL TIME STUDENT STATUS.

Add (A)	Drop (D)	Relationship of Eligible Dependents	Full Name (Last, First, MI)	Date of Birth MM/DD/YY	Gender (M) (F)	Social Security No./Member No.
A	D	Spouse				
A	D	Child 1				
A	D	Child 2				
A	D	Child 3				
A	D	Child 4				

Other Health Coverage (This section must be completed)

Is your spouse employed? ☐ Yes ☐ No Employer______________________
Will you or any other family member be covered through another health insurance plan? ☐ Yes ☐ No
If YES, please list names of covered individuals.______________________
Insurance Company Name______________Policy Number______________Effective Date______________Phone Number______________
Does this include a prescription benefit? ☐ Yes ☐ No

Terms and Conditions

A. I understand that I am responsible for promptly reporting to my employer any changes in my marital status, my number of eligible dependents or change in my residence.

B. I hereby authorize any hospital, physician, surgeon, or pharmacist to release any information requested by Bluegrass Family Health, Inc. with respect to any claim of the delivery of medical care on behalf of myself or a covered dependent. A photocopy of this authorization will serve the same as the original. This authorization is not the same as a HIPAA Authorization.

C. I agree that any medical benefits payable on my behalf under my employer's Group Medical Benefits Plan may be paid directly to the provider of care.

D. I understand and agree that no benefits shall take effect until this enrollment/change form is **approved** by Bluegrass Family Health Inc. Upon such acceptance, Bluegrass Family Health, Inc. shall as soon as possible, issue an identification card(s) to me.

E. I authorize my employer to make the necessary deductions from my pay or any disability or retirement annuity benefits to which I may be entitled under any group plan sponsored by my employer while I am enrolled in Bluegrass Family Health, Inc. until this authorization is revoked by me in writing.

F. I understand that I must be actively at work on the effective date of coverage or the effective date will be on the date I return to work, unless my absence is due to a medical condition.

Employee Signature______________________________ Date______________

Rev. 10/03

APPENDIX H

USE AND DISCLOSURE AUTHORIZATION FORM

Bluegrass Family Health

Authorization for the Use and Disclosure of Individually Identifiable Health Information

I, ____, hereby authorize Bluegrass Family Health to use and/or disclose my protected
Name and Social Security Number of Insured

health information described below to ____.
Name of person or organization that is to receive the information

This authorization applies to the information described below (mark all those that apply):

❑ Records covering the period of time for ________________________ to ________________________.

❑ Information regarding the following condition or injury [please describe] ____

on or about this date ____.

❑ Other [please be specific and include dates] ____.

The information will be used and/or disclosed for the following purpose (check one):

❑ At the request of the individual

❑ Other [please describe in specific detail] ____.

I understand that this authorization is voluntary and that I may refuse to sign. My refusal to sign will not affect my eligibility for benefits or enrollment, payment for or coverage of services, or the ability to obtain treatment, **except that**,

- if this authorization is for BFH to determine eligibility before enrollment, and the requested use or disclosure is not for psychotherapy notes, then BFH reserves the right to deny enrollment or eligibility for benefits if I refuse to sign, **or**
- if this authorization is to disclose health information to another party based on health care that is provided solely to obtain such information, then BFH reserves the right to deny that health care if I refuse to sign.

I understand that I have a right to request and receive a copy of BFH's Notice of Privacy Practices.

I understand that I have the right to revoke this authorization at any time by sending written notification to Bluegrass Family Health, Attention Privacy Officer, 651 Perimeter Drive, Suite 300, Lexington, KY 40517.

I understand that a revocation is not effective to the extent that the persons I have authorized to use and/or disclose my individually identified health information have acted in reliance upon this authorization.

I further understand that if this authorization was obtained as a condition of obtaining insurance coverage, other law provides BFH with the right to contest a claim under the policy, or the policy itself.

I understand the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

This authorization will expire in **two (2) years**. If you wish for this authorization to expire **sooner**, please enter the date of expiration: [please list a **specific date**]: ____.

Please keep a copy of this authorization for your records.

____ ________________________________
Signature of Insured **or** Personal Representative (i.e., Legal Guardian, Power of Attorney) Date

____ ________________________________
Print Name of Insured or Personal Representative Member ID Number of Insured

____
Description of Personal Representative (Please provide representative documentation)

APPENDIX I

NOTICE OF PRIVACY PRACTICES

PRIVACY NOTICE

NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

At Bluegrass Family Health, we respect the confidentiality of your health information and will protect your information in a responsible and professional manner. We are required by law to maintain the privacy of your health information and to send you this Privacy Notice and abide by the terms of this Privacy Notice.

This Notice explains how we use information about you and when we can share that information with others. It also informs you of your rights with respect to your health information and how you can exercise those rights. Throughout this notice we will talk about words like, 'protected health information (PHI)' and 'health information'. These words refer to any information that can be individually identified as belonging to you. Protected Health Information (PHI) can be provided, transmitted or maintained in many ways, such as, but not limited to: mail, fax, copier, telephone, e-mail or paper mediums.

HOW WE USE OR SHARE PROTECTED HEALTH INFORMATION

We are allowed by law to use or share your PHI *without* your consent, if it is for treatment, payment, or health care operations. Listed below are some examples of how we can use or share your PHI.

- We may share your PHI with your doctors, hospitals or other medical providers to help them provide medical care to you. For example, if you are in the hospital, we may give them access to any medical records sent to us by your doctor.
- We may use or share your PHI with others to help manage your health care. For example, we might talk to your doctor to suggest a disease management or wellness program that could help improve your health.
- We may use your PHI to determine eligibility and process your claims.
- We may share your PHI with another covered entity to determine who is primary on your claims.
- We may share your PHI with entities that we have delegated services to, such as but not limited to, our pharmacy benefits manager. We will not share your PHI with any delegated entity unless they agree to keep it protected.
- We may use or share your PHI to give you information about alternative medical treatments and programs or about health related products and services that you may be interested in. For example, we might send you information about smoking cessation or weight loss programs.

There are also state and federal laws that require us to release your PHI to others. We may be required to provide information for the following reasons:

- We may report information to state and federal agencies that regulate us such as the U.S. Department of Health and Human Services and the Kentucky Department of Insurance.
- We may share information for public health activities. For example, we may report information to the Food and Drug Administration for investigating or tracking of prescription drug and medical device problems.
- We may share information with a health oversight agency for certain oversight activities (for example, audits, inspections, licensure and disciplinary actions.)
- We may use or share information for procurement, banking or transplantation of organs, eyes or tissue.
- We may report information on job-related injuries because of requirements of state workers' compensation laws.

We are prohibited from using or sharing your PHI that may be prohibited by any applicable federal or state law. The Commonwealth of Kentucky prohibits us from sharing PHI as it relates mental health and chemical dependency.

IF ONE OF THE ABOVE REASONS DOES NOT APPLY, WE MUST GET YOUR WRITTEN PERMISSION (AUTHORIZATION) TO USE OR SHARE YOUR PROTECTED HEALTH INFORMATION (PHI). IF YOU GIVE US WRITTEN PERMISSION (AUTHORIZATION) AND YOU LATER CHANGE YOUR MIND, YOU MAY REVOKE YOUR WRITTEN PERMISSION AT ANY TIME. (SEE APPENDIX A FOR A BLANK COPY)

WHAT ARE YOUR RIGHTS?

- **You have the right to inspect and copy PHI** that is maintained by us and/or any of our business associates. However, you do not have the right to access certain types of information, and we may decide not to provide you with copies of:
  - psychotherapy notes;
  - information compiled in reasonable anticipation of, or for use in a civil, criminal or administrative action or proceeding; and
  - information subject to certain federal laws governing biological products and clinical laboratories.
- **You have the right to ask us to restrict** how we use or disclose your information for treatment, payment, or health care operations. You also have the right to ask us to restrict information that we have been asked to give to family members or to others who are involved in your health care or payment for your health care. *Please note that while we will try to honor your request, we are not required to agree to these restrictions.*
- **You have the right to ask to receive confidential communications** of information. For example, if you believe that you would be harmed if we send your information to your current mailing address (in situations involving domestic disputes or violence), you can ask us to send the information by alternative means, such as fax, or to an alternative address. We will accommodate your reasonable requests as explained above.

- **You have a right to receive a copy of this notice upon request at any time.** You can also view a copy of the notice on our web site at www.bgfh.com.
- **You have a right to amend** your protected health information (PHI).

  In certain other situations, we may deny your request to inspect or obtain a copy of your information. If we deny your request, we will notify you in writing and may provide you with a right to have the denial reviewed.

- You have the right to receive an accounting of how we have used or shared your PHI. Please note that we are not required to provide you with an accounting of the following information:

➢ Any information collected prior to April 14, 2003;
➢ Information disclosed to you or pursuant to your authorization;
➢ Information used or shared for treatment, payment and health care operations;
➢ Information that is incidental to a use or disclosure otherwise permitted;
➢ Information disclosed for a facility's directory or to persons involved in your care or other notification purposes;
➢ Information disclosed for national security or intelligence purposes;
➢ Information disclosed to correctional institutions, law enforcement officials or health oversight agencies;
➢ Information that was disclosed or used as part of a limited data set for research, public health, or health care operations purposes.

We may require that your request be in writing. We will act on your request for an accounting within 60 days. We may need additional time to act on your request. If so, we may take up to an additional 30 days. Your first accounting request will be free. We will continue to provide you with one free accounting upon request every 12 months. If you request an additional accounting within 12 months of receiving your free accounting, we may charge you a fee. We will inform you in advance of the fee and provide you with an opportunity to withdraw or modify your request.

Should any of our privacy practices change, we reserve the right to change the terms of this notice and to make the new notice effective for all protected health information (PHI) we maintain. Once revised, we will provide the new notice to you by direct mail and post it on our website.

Please contact our Privacy Officer if you have any questions about this notice or about how we use or share protected health information (PHI), or if you believe your privacy rights have been violated.

Bluegrass Family Health
Attn.: Privacy Officer
651 Perimeter Drive, #300
Lexington, Kentucky 40517
859-335-4141
1-800-787-2680 ext. 4141
859-335-3720 fax

privacyofficer@bgfh.com

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint at 200 Independence Avenue, S.W., Washington, D.C. 20201. Telephone: 202-619-0257 or 877-696-6775.