COMMONWEALTH OF KENTUCKY

SUMMARY PLAN DESCRIPTION

COMMONWEALTH OF KENTUCKY HEALTH FLEXIBLE SPENDING ACCOUNT

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

Benefits under this *Plan* are provided on a self-insured basis, which means that payment for benefits is ultimately the sole financial responsibility of the Plan Sponsor. Certain administrative services with respect to the *Plan*, such as claims processing, are provided under a services agreement.

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

Louisville Plan Number: 236117

Lexington Plan Number: 236134

Northern Kentucky Plan Number: 236215

Effective Date: January 1, 2006

Plan Year: January 1, 2006 through December 31, 2006

Employer's Federal Tax Identification Number: 61-0600439

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PLAN INFORMATION

GENERAL INFORMATION ABOUT THE PLAN

Commonwealth of Kentucky (the "*Employer*") has established the Commonwealth of Kentucky Health Flexible Spending Account (the "*Plan*"). The *Plan* allows you to use *Pre-tax Contributions* to pay for qualified expenses. The Commonwealth of Kentucky Health Flexible Spending Account contains two components:

(i) A Cafeteria *Plan* Component. The Cafeteria *Plan* Component allows you to pay your share of certain underlying welfare benefit plans (called "Benefit Plan Options) with *Pre-tax Contributions*.

(ii) The Health Flexible Spending Account ("Health FSA"). The Health FSA allows you to elect to use a specified amount of *Pre-tax Contributions* to be used for reimbursement of Eligible Medical Expenses. The Health FSA is intended to qualify as a *Code* Section 105 self-insured medical reimbursement *plan*.

Each of these components is summarized in this document. Each summary and the attached Appendices constitute the *Summary Plan Description* for the Commonwealth of Kentucky Health Flexible Spending Account. The *SPD* (collectively, the *Summary Plan Description* or "*SPD*") describes the basic features of the Plan(s), how they operate, and how you can get the maximum advantage from them. The *Plan*(s) are also established pursuant to *plan* documents into which the *SPD* has been incorporated. However, if there is a conflict between the official *plan* document and the *SPD*, the *plan* document will govern. Certain words in this Summary are italicized. Italicized words reflect important terms that are specifically defined in Appendix IV of this Summary. You should pay special attention to these terms as they play an important role in defining your rights and responsibilities under the *Plan*(s).

Participation in the *Plan*(s) does not give any *Participant* the right to be retained in the employ of his or her *Employer* or any other right not specified in the *Plan*. If you have any questions regarding your rights and responsibilities under the *Plan*(s), you may also contact the *Plan Administrator*.

PLAN CONTACT INFORMATION

If you have any questions about the Commonwealth of Kentucky Health Flexible Spending Account, you should contact the Third Party Administrator or the *Plan Administrator*.

Employer / Plan Sponsor

Commonwealth of Kentucky
Personnel Cabinet, Department for Employee Insurance
200 Fair Oaks Lane, Suite 501
Frankfort, KY 40601
502-564-0350
502-564-0351

Plan Administrator

Commonwealth of KY
Personnel Cabinet, Department for Employee Insurance
200 Fair Oaks Lane, Suite 501
Frankfort, KY 40601
502-564-0350
502-564-0351

Third Party Administrator

Humana
Attn: Humana Spending Account Administration Team
P.O. Box 19068
Green Bay, WI 54307

CAFETERIA PLAN COMPONENT SUMMARY

PARTICIPATION

You are eligible to participate in this *Plan* if you satisfy the below Eligibility Requirements. Those *employees* who actually participate in the Cafeteria *Plan* are called "*Participant*s."

"Employee" shall mean a person, including an elected public official, who is regularly employed by any department, board, agency, or branch of state government, and who is a contributing member to any one (1) of the retirement systems administered by the state.

Eligibility for coverage under any given Benefit *Plan* Option shall be determined not by this *Plan* but by the terms of that Benefit *Plan* Option. The terms of eligibility of this Cafeteria *Plan* do not override the terms of eligibility of each of the Benefit *Plan* Options. In other words, if you are eligible to participate in this Cafeteria *Plan*, it does not necessarily mean you are eligible to participate in the Benefit *Plan* Options.

You may be *required* to pay for any Benefit *Plan* Option coverage that you elect with *Pre-tax Contributions*. When you elect to participate both in a Benefit *Plan* Option and this Cafeteria Plan, an amount equal to your share of the annual cost of those Benefit Plan Options that you choose divided by the applicable number of pay periods you have during that *Plan Year* is deducted from each paycheck after your election date. If you have chosen to use *Pre-tax Contributions* (or it is a plan requirement), the deduction is made before any applicable federal and/or state taxes are withheld.

ENROLLMENT

The purpose of the Cafeteria Plan is to allow eligible *employees* to pay for certain benefit plans (Benefit Plan Options) with pre-tax dollars ("*Pre-tax Contributions*"). Each *employee* of the *Employer* (or an Affiliated Employer) who

(i) satisfies the Cafeteria Plan Eligibility Requirements and
(ii) is also eligible to participate in any of the Benefit Plan Options will be eligible to participate in this Cafeteria Plan.

If you have satisfied the Cafeteria Plan's eligibility requirements, you automatically become a *Participant*. You may enroll during the year if you previously elected not to participate and you experience a change described below that allows you to become a *participant* during the year. If that occurs, you must complete an election change form during the Election Change Period.

The Cafeteria Plan has three election periods:

(i) the “Initial Election Period,” (Upon Hire)
(ii) the “Annual Election Period,” (Open Enrollment) and
(iii) the “Election Change Period”, which is the period following the date you have a *Qualifying Event*. The following is a summary of the Initial Election Period and the Annual Election Period.

The Initial Election Period

Upon satisfying the Health FSA Eligibility Requirements, you are automatically enrolled in the Commonwealth of Kentucky Health Flexible Spending Account. The election that you make during the Initial Election Period is effective for the remainder of the *Plan Year* and generally cannot be changed during the *Plan Year* unless you have a qualifying event.

The Annual Election Period

The Cafeteria Plan also has an "Annual Election Period" during which you may enroll if you did not enroll during the Initial Election Period or change your elections for the next *Plan Year*. The Annual Election Period will be identified in the enrollment material distributed to you prior to the Annual Election Period. The election that you make during the Annual Election Period is effective the first day of the next *Plan Year* and cannot be changed during the entire *Plan Year* unless you have a *Qualifying Event* described below.

ELECTION CHANGES

If you experience a Qualifying Event as described in the Cafeteria Plan Summary and in the Election Change Chart, you may make the permitted election changes described in the Election Change Chart if you complete and submit an election change form within 30 days after the date of the event, unless the event is for birth of a newborn, or adoption or placement for adoption, in which you have 60 days from the date of birth, or placement to submit an election change form. If you are participating in an insured arrangement that provides a longer election change period, the election change period described in the insurance policy will apply.

Generally, you cannot change your election under this Cafeteria Plan during the *Plan Year*. There are, however, a few exceptions. First, your election will automatically terminate if you terminate employment or lose eligibility under this Cafeteria Plan or under all of the Benefit Plan Options that you have chosen.

Second, you may voluntarily change your election during the *Plan Year* if you satisfy the following conditions (prescribed by federal law):

(a) You experience a "*Qualifying Event*" that affects your eligibility under this Cafeteria Plan and/or a Benefit Plan Option; and
(b) You complete and submit a written Election Change Form within the Election Change period.

*Qualifying Event*s recognized by this Cafeteria Plan, and the rules surrounding election changes in the event you experience a *Qualifying Event* are described in the Election Change Chart attached to this *SPD*.

If coverage under a Benefit Plan Option ends, the corresponding *Pre-tax Contributions* for that coverage will automatically end. No election is needed to stop the contributions.

LEAVE OF ABSENCE

The following is a general summary of the rules regarding participation in the Cafeteria Plan (and the Benefit Plan Options) during a leave of absence. The specific election changes that you can make under this Cafeteria Plan following a leave of absence are described in the Election Change Chart.

(a) If you go on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 (FMLA), the *Employer* will continue to maintain your Benefit Plan Options that provide health coverage on the same terms and conditions as though you were still active to the extent required by FMLA (e.g., the *Employer* will continue to pay its share of the contribution to the extent you opt to continue coverage).

(b) Your *Employer* may elect to continue all health coverage for *Participant*s while they are on paid leave (provided *Participant*s on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the contributions by the method normally used during any paid leave (for example, with *Pre-tax Contributions* if that is what was used before the FMLA leave began).

(c) In the event of unpaid FMLA leave (or paid leave where coverage is not required to be continued), if you opt to continue your group health coverage, you may pay your share of the contribution in one of the following ways:

(i) With after-tax dollars while you are on leave,

(ii) You may pre-pay all or a portion of your share of the contribution for the expected duration of the leave with *Pre-tax Contributions* from your pre-leave *compensation* by making a special election to that effect before the date such *compensation* would normally be made available to you. However, pre-payments of *Pre-tax Contributions* may not be utilized to fund coverage during the next *Plan Year*.

(iii) By other arrangements agreed upon between you and the *Plan Administrator* (for example, the *Plan Administrator* may fund coverage during the leave and withhold amounts from your *compensation* upon your return from leave).

The payment options provided by the *Employer* will be established in accordance with *Code* Section 125, FMLA and the *Employer*'s internal policies and procedures regarding leaves of absence and will be applied uniformly to all *Participant*s. Alternatively, the *Employer* may require all *Participant*s to continue coverage during the leave. If so, you may elect to discontinue your share of the required contributions until you return from leave. Upon return from leave, you will be required to repay the contribution not paid during the leave in a manner agreed upon with the Administrator. The Election Change Chart will let you know whether you are able to drop your coverage or whether you are required to continue coverage during the leave.

(d) If your coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), you will be permitted to re-enter the Cafeteria Plan and the Benefit Plan Option upon return from such leave on the same basis as you were participating in the plans prior to the leave, or as otherwise required by the FMLA. Your coverage under the Benefit Plan Options providing health coverage may be automatically reinstated provided that coverage for *Employees* on non-FMLA leave is automatically reinstated upon return from leave.

(e) The *Employer* may, on a uniform and consistent basis, continue your group health coverage for the duration of the leave following your failure to pay the required contribution. Upon return from leave, you will be required to repay the contribution in a manner agreed upon by you and the *Employer*.

(f) If you are commencing or returning from unpaid FMLA leave, your election under this Cafeteria Plan for Benefit Plan Options providing non-health benefits shall be treated in the same manner that elections for non-health Benefit Plan Options are treated with respect to *Participant*s commencing and returning from unpaid non-FMLA leave.

(g) If you go on an unpaid non-FMLA leave of absence (e.g., personal leave, sick leave, etc.) that does not affect eligibility in this Cafeteria Plan or a Benefit Plan Option offered under this Cafeteria Plan, then you will continue to participate and the contribution due will be paid by pre-payment before going on leave, by *after-tax contributions* while on leave, or with catch-up contributions after the leave ends, as may be determined by the Administrator. If you go on an unpaid leave that affects eligibility under this Cafeteria Plan or a Benefit Plan Option, the election change rules described herein will apply. The *Plan Administrator* will have discretion to determine whether taking an unpaid non-FMLA leave of absence affects eligibility.

TERMINATION OF COVERAGE

Although the *Employer* expects to maintain the Cafeteria Plan indefinitely, it has the right to modify or terminate the Cafeteria Plan at any time and for any reason. Plan amendments and terminations will be conducted in accordance with the terms of the Plan Document.

Your coverage under the Cafeteria Plan ends on the earliest of the following to occur:

(i) The date that you make an election not to participate in accordance with this Cafeteria Plan Summary;
(ii) The date that you no longer satisfy the Eligibility Requirements of this Cafeteria Plan or all of the Benefit Plan Options;
(iii) The date that you terminate employment with the *Employer*; or
(iv) The date that the Cafeteria Plan is either terminated or amended to exclude you or the class of *employees* of which you are a member.

If your employment with the *Employer* is terminated during the *Plan Year* or you otherwise cease to be eligible, your active participation in the Cafeteria Plan will ***automatically*** cease, and you will not be able to make any more *Pre-tax Contributions* under the Cafeteria Plan except as otherwise provided pursuant to *Employer* policy or individual arrangement (e.g., a severance arrangement where the former *employee* is permitted to continue paying for a Benefit Plan Option out of severance pay on a pre-tax basis).

If you are rehired within the same *Plan Year* and are eligible for the Cafeteria Plan (or you become eligible again), you may make new elections if you are rehired or become eligible again more than 30 days after you terminated employment or lost eligibility (subject to any limitations imposed by the Benefit Plan Option(s)). If you are rehired or again become eligible within 30 days or less of your termination date, your Cafeteria Plan elections that were in effect when you terminated employment or stopped being eligible will be reinstated and remain in effect for the remainder of the *Plan Year* (unless you are allowed to change your election in accordance with the terms of the Plan).

TAX ADVANTAGES

You save both federal income tax and FICA (Social Security) taxes by participating in the Cafeteria Plan. Cafeteria Plan participation will reduce the amount of your taxable *compensation*. Accordingly, there could be a decrease in your Social Security benefits and/or other benefits (e.g., pension, disability, and life insurance) that are based on taxable *compensation*. Participating in the Plan can actually increase your take home pay. Consider the following example:

You are married and have one child. The *Employer* pays for 80% of your medical insurance premiums, but only 40% for your family. You pay $2,400 in premiums ($400 for your share of the *employee*-only premium, plus $2,000 for family coverage under the *Employer*'s major medical insurance plan). You earn $50,000 and your *spouse* (a *student*) earns no income. You file a joint tax return. Please view the below chart example.

	If you participate in the Cafeteria Plan		If you do not participate in the Cafeteria Plan
1. Gross Income	$50,000		$50,000
2. Salary Reductions for Premiums	$2,400 (pre-tax)		$0
3. Adjusted Gross Income	$47,600		$50,000
4. Standard Deduction	($9,700)		($9,700)
5. Exemptions	($9,300)		($9,300)
6. Taxable Income	$28,600		$31,000
7. Federal Income Tax (Line 6 x applicable tax schedule)	($3,590)		($3,950)
8. FICA Tax (7.65% x Line 3 amount)	($3,641)		($3,825)
9. After Tax Contributions	($0)		($2,400)
10. Pay after taxes and contributions	$40,365		$39,821
11. Take Home Pay Difference	$544		

HEALTH FSA ELIGIBILITY REQUIREMENTS

PARTICIPATION

Each *employee* who satisfies the Health FSA Eligibility requirements is eligible to participate on the Health FSA Eligibility Date.

"Employee" shall mean a person, including an elected public official, who is regularly employed by any department, board, agency, or branch of state government, and who is a contributing member to any one (1) of the retirement systems administered by the state.

If you have otherwise satisfied the Health FSA's Eligibility requirements, you become a *participant* in the Health FSA by electing Health Care Reimbursement benefits during the Initial or Annual Election Periods described in the Cafeteria Plan Summary. Your participation in the Health FSA will be effective on the date that you make the election or your Health FSA Eligibility Date, whichever is later. If you have made an election to participate and you want to participate during the next *Plan Year*, you must make an election during the Annual Election Period, even if you do not change your current election. Evergreen elections do not apply to Health FSA elections.

ENROLLMENT

If you elect to participate in the Health FSA, the *Employer* will establish a "Health Care Account" to keep a record of the reimbursements you are entitled to, as well as the contributions you elected to withhold for such benefits during the *Plan Year*. No actual account is established; it is merely a bookkeeping account. Benefits under the Health FSA are paid as needed from the *Employer*'s general assets.

During the enrollment period, you will specify the amount of Health Care Reimbursement you wish to pay for with *Pre-tax Contributions*. Thereafter, each paycheck will be reduced by an amount equal to a pro-rata share of the annual contribution.

You may elect any annual reimbursement amount subject to the maximum annual Health Care Reimbursement Amount and Minimum Reimbursement Amount allowed for the plan. The Maximum Annual Reimbursement Amount each year may not exceed the lesser of Health FSA reimbursement amount elected for that year or $2,880. The minimum reimbursement amount that may be elected under the Health FSA is $120.

So long as coverage is effective, the full, annual amount of Health Care Reimbursement you have elected, reduced by the amount of previous Health Care Reimbursements received during the Year, will be available at any time during the *Plan Year*, without regard to how much you have contributed.

HEALTH FSA ELIGIBILITY REQUIREMENTS (continued)

Any change in your Health FSA election also will change the maximum available reimbursement for the period of coverage after the election. Such maximum available reimbursements will be determined on a prospective basis only by a method determined by the *Plan Administrator* that is in accordance with applicable law. The *Plan Administrator* (or its designated claims administrator) will notify you of the applicable method when you make your election change.

An *Employer* may choose to pay for a share of the cost of the Benefit Plan Options you choose with Nonelective *Employer* Contributions. The amount of Nonelective *Employer* Contributions that is applied by the *Employer* towards the cost of the Benefit Plan Option(s) for each *Participant* and/or level of coverage is subject to the sole discretion of the *Employer* and it may be adjusted upward or downward in the *Employer*'s sole discretion at any time. The Nonelective *Employer* Contribution amount will be calculated for each *Plan Year* in a uniform and nondiscriminatory manner and may be based upon your dependent status, commencement, or termination date of your employment during the *Plan Year*, and such other factors that the *Employer* deems relevant. In no event will any *Nonelective Contribution* be disbursed to you in the form of additional, taxable *compensation* except as otherwise provided in the enrollment material.

Employees, who waive medical coverage, will receive *Employer* Health Flexible Spending Account contributions. The Commonwealth of Kentucky will contribute $2,604 per each *employee* who waives medical coverage. *Employer* contributions will be allocated to the Health Flexible Spending Accounts as described below:

Month	Employer Contributions
January 1, 2006 to June 30, 2006	$234 allocated per month
July 1, 2006 to December 31, 2006	$200 allocated per month

ELIGIBLE DEPENDENTS

1. Legally recognized *spouse*;

2. Unmarried natural blood related child, step-child, legally adopted child, or child for which the *employee* has legal guardianship whose age is less than the limiting age. Each child must legally qualify as a dependent as defined by the United States Internal Revenue Service.

   The limiting age for each dependent child is to the end of the year of his/her 23rd birthday. The dependent must reside with the *employee* in a parent-child relationship and who is dependent on the *employee* for more than 50% of his/her support and maintenance.

HEALTH FSA ELIGIBILITY REQUIREMENTS (continued)

Qualifying Relative: defined as the member's unmarried child(ren) including foster child(ren), grandchild(ren) or step-child(ren), who: (1) has the same principal abode as the member and is a member of the member's household; (2) has income less than $3,200 for the 2005 tax year; (3) received over half of his/her support from the member during the calendar year in which the member's taxable year begins; and (4) is not any other person's qualifying child.

A child will not qualify as a member's qualifying dependent or qualifying relative in three instances: (1) if a member is the dependent of a taxpayer, then the member may not have a qualifying child or relative, (2) if a child files a joint return with his/her *spouse*, then that individual cannot be a dependent of another person, or (3) the child is not a citizen or resident of the United States or a resident of Canada or Mexico.

Adopted children and children placed for adoption are subject to all terms and provisions of the Plan, with the exception of the pre-existing condition limitation.

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

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

Dependents may only be covered under one state-sponsored plan. Unless both *employees* agree in writing, the *employee* with custody shall have first option to cover the dependent children.

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

1. Mentally retarded or permanently physically handicapped;

2. Incapable of self-sustaining employment;

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

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

5. Unmarried.

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

ELECTION CHANGES

You can change your election under the Health FSA in the following situations:

(i) For any reason during the Annual Election Period. You can change your election during the Annual Election Period for any reason. The election change will be effective the first day of the Plan Year following the end of the Annual Election Period.
(ii) Following a Qualifying Event. You may change your Health FSA election during the Plan Year only if you experience an applicable Qualifying Event.

LEAVE OF ABSENCE

Refer to the Cafeteria Plan Summary and the Election Change Chart to determine what, if any, specific changes you can make during a leave of absence. If your Health FSA coverage ceases during an FMLA leave, you may, upon returning from FMLA leave, elect to be reinstated in the Health FSA at either

(i) the same coverage level in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or
(ii) at the same coverage level that is reduced pro-rata for the period of FMLA leave during which you did not make any contributions.

Under either scenario, expenses incurred during the period that your Health FSA coverage was not in effect are not eligible for reimbursement under this Health FSA.

TERMINATION OF COVERAGE

Although the *Employer* expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time and for any reason.

Your coverage under the Health FSA ends on the earlier of the following to occur:

(i) the date that you elect not to participate in accordance with the Cafeteria Plan Summary;
(ii) the last day of the *Plan Year* unless you make an election during the Annual Election Period;
(iii) the date that you no longer satisfy the Health FSA Eligibility Requirements;
(iv) the date that you terminate employment; or
(v) the date that the Plan is terminated or you or the class of eligible *employees* of which you are a member are specifically excluded from the Plan.

You may be entitled to elect Continuation Coverage under the Health FSA once your coverage ends because you terminate employment or experience a reduction in hours of employment.

Coverage for your Eligible Dependents ends on earliest of the following to occur:

(i) the date your coverage ends;
(ii) the date that your dependents cease to be eligible dependents (e.g. you and your *spouse* divorce);
(iii) the date the Plan is terminated or amended to exclude the individual or the class of Dependents of which the individual is a member from coverage under the Health FSA.

You and/or your covered dependents may be entitled to continue coverage if coverage is lost for certain reasons. For additional information, please reference the Continuation of Coverage section within this *SPD.*

HEALTH FSA REIMBURSEMENT

ELIGIBLE CLAIMS EXPENSE

An “Eligible Medical Expense” is an expense that has been incurred by you and/or your eligible dependents that satisfies the following conditions:

- The expense is for "medical care" as defined by *Code* Section 213(d);
- The expense has not been reimbursed by any other source and you will not seek reimbursement for the expense from any other source.

The *Code* generally defines "medical care" as any amounts incurred to diagnose, treat, or prevent a specific medical condition or for purposes of affecting any function or structure of the body. Not every health related expense you or your eligible dependents incur constitutes an expense for “medical care.” For example, an expense is not for “medical care”, as that term is defined by the *Code*, if it is merely for the beneficial health of you and/or your eligible dependents (e.g. vitamins or nutritional supplements that are not taken to treat a specific medical condition) or for cosmetic purposes, unless necessary to correct a deformity arising from illness, injury, or birth defect. You may, in the discretion of the Third Party Administrator/*Plan Administrator*, be required to provide additional documentation from a health care provider showing that you have a medical condition and/or the particular item is necessary to treat a medical condition. Expenses for cosmetic purposes are also not reimbursable unless they are necessary to correct an abnormality caused by illness, injury or birth defect.

In addition, certain expenses that might otherwise constitute “medical care” as defined by the *Code* are not reimbursable under any Health FSA (per IRS regulations):

- Health insurance premiums;
- Expenses incurred for qualified long term care services; and
- Any other expenses that are specifically excluded by the *Employer*

Please reference Appendix III for a list of Eligible Medical Expenses.

Eligible Medical Expenses must be incurred ***during*** the *Plan Year* and while you are a *participant* in the Plan. “Incurred,” means that the service or treatment giving rise to the expense has been provided. If you pay for an expense before you are provided the service or treatment, the expense may not be reimbursed until you have been provided the service or treatment. You may not be reimbursed for any expenses arising before the Health FSA becomes effective or for any expenses incurred after the close of the *Plan Year*, or, after a separation from service or loss of eligibility (except for expenses incurred during an applicable COBRA continuation period).

CLAIMS REIMBURSEMENT

Under this Health FSA, you have two reimbursement options. You can complete and submit a written claim for reimbursement (see "Traditional Paper Claims" below for more information). Alternatively, you can use an electronic payment card (see "Electronic Payment Card" below for more information) to pay the expense. In order to be eligible for the Electronic Payment Card, you must agree to abide by the terms and conditions of the Electronic Payment Card Program (the "Program") as set forth herein and in the Electronic Payment Cardholder Agreement (the "Cardholder Agreement") including any fees applicable to participate in the program, limitations as to card usage, the Plan's right to withhold and offset for ineligible claims, etc. The following is a summary of how both options work.

Traditional Paper Claims: When you incur an Eligible Medical Expense, you file a claim with the Plan's Third Party Administrator by completing and mailing or faxing a Request for Reimbursement Form. Forms can be mailed to P.O. Box 19068, Green Bay, WI 54307 or faxed to (920) 632-9200. You may obtain a Request for Reimbursement Form from the *Plan Administrator* or the Third Party Administrator. You must include with your Request for Reimbursement Form a written statement from an independent third party (e.g., a receipt, EOB, etc.) associated with each expense that indicates the following:

(i) The nature of the expense (e.g. what type of service or treatment was provided).
(ii) The date the expense was incurred; and
(iii) The amount of the expense.

The Third Party Administrator will process the claim once it receives the Request for Reimbursement Form from you. Reimbursement for expenses that are determined to be Eligible Medical Expenses will be made as soon as possible after receiving the claim and processing it. If the expense is determined to not be an "Eligible Medical Expense," you will receive notification of this determination. You must submit all claims for reimbursement for Eligible Medical Expenses during the *Plan Year* in which they were incurred or during the Run Out Period.

Electronic Payment Card: The Electronic Payment Card allows you to pay for Eligible Medical Expenses at the time that you incur the expense. Here is how the Electronic Payment Card works.

(a) *You must make an election to use the card.* In order to be eligible for the Electronic Payment Card, you must agree to abide by the terms and conditions of the Program as set forth herein and in the Electronic Payment Cardholder Agreement (the "Cardholder Agreement") including any fees applicable to participate in the Program, limitations as to card usage, the Plan's right to withhold and offset for ineligible claims, etc.

You must agree to abide by the terms of the Program both during the Initial Election Period and during each Annual Election Period. A Cardholder Agreement will be provided to you. The card will be turned off effective the first day of each *Plan Year* if you do not affirmatively agree to abide by the terms of the Program during the preceding Annual Election Period. The Cardholder Agreement is part of the terms and conditions of your Plan and this *SPD*.

(b) *The card will be turned off when employment or coverage terminates.* The card will be turned off when you terminate employment or coverage under the Plan. Contact your Third Party Administrator for reactivation of the electronic payment card after submission of your initial COBRA premium payment.

(c) *You must certify proper use of the card.* As specified in the Cardholder Agreement, you certify during the applicable Election Period that the amounts in your Health FSA will only be used for Eligible Medical Expenses (i.e. medical care expenses incurred by you, your *spouse*, and your tax dependents) and that you have not been reimbursed for the expense and that you will not seek reimbursement for the expense from any other source. Failure to abide by this certification will result in termination of card use privileges.

(d) *Health FSA reimbursement under the card is limited to health care providers (including pharmacies).* Use of the card for Health FSA expenses is limited to merchants who are health care providers (doctors, pharmacies, etc.).

(e) *You swipe the card at the health care provider like you do any other credit or debit card.* When you incur an Eligible Medical Expense at a doctor's office or pharmacy, such as a co-payment or prescription drug expense, you swipe the card at the provider's office much like you would a typical credit or debit card. The provider is paid for the expense up to the maximum reimbursement amount available under the Health FSA (or as otherwise limited by the Program) at the time that you swipe the card. Every time you swipe the card, you certify to the Plan that the expense for which payment under the Health FSA is being made is an Eligible Medical Expense and that you have not been reimbursed from any other source nor will you seek reimbursement from another source.

If you waive your health insurance and have the employer contribution deposited in a health FSA, you can only use the electronic payment card at a physician or other provider's office. You cannot use the card at a pharmacy. If you are the plan holder of a cross-reference plan, you can use the electronic payment card at a physician or other provider's office. You can also use the card at a pharmacy to pay for your prescriptions and for the prescriptions of your covered dependents.

If you are not the plan holder of a cross-reference plan, you can only use the electronic payment card at a physician or other provider's office to pay for your charges and for covered dependents' charges. You cannot use the card at a pharmacy to pay for your prescriptions or for the prescriptions of your covered dependents.

HEALTH FSA REIMBURSEMENT (continued)

(f) *You must obtain and retain a receipt/third party statement each time you swipe the card.* You must obtain a third party statement from the health care provider (e.g., receipt, invoice, etc.) that includes the following information each time you swipe the card:

- The nature of the expense (e.g., what type of service or treatment was provided).
- The date the expense was incurred.
- The amount of the expense.

You must retain this receipt for one year following the close of the *Plan year* in which the expense is incurred. Even though payment is made under the card arrangement, a written third party statement is required to be submitted (except as otherwise provided in the Cardholder Agreement). You will receive a letter from the Claims Administrator that a third party statement is needed. You must provide the third party statement to the Claims Administrator within 45 days (or such longer period provided in the letter from the Claims Administrator) of the request.

(g) *There are situations where the third party statement will not be required to be provided to the Claims Administrator.* There may be situations in which you will not be required to provide the written statement to the claims administrator. More detail as to which situations apply under your Plan is specified in the Cardholder Agreement:

- **Co-Pay Match:** As specified in the Cardholder Agreement, no written statement is necessary if the Electronic Payment Card payment matches a specific co-payment you have under the component medical plan for the particular service that was provided. For example, if you have a $10 co-pay for physician office visits, and the payment was made to a physician office in the amount of $10, you will not be required to provide the third party statement to the Claims Administrator.

- **Previously Approved Claim Match:** As specified in the Cardholder Agreement, no written statement is required if the expense is the same as the amount, duration and provider as a previously approved expense For example, the claims administrator approves a 30 count prescription with 3 refills that was purchased at ABC Pharmacy. Each time the card is swiped for subsequent refills at ABC Pharmacy the receipt need not be provided to the Claims Administrator if the expense incurred is the same amount.

- **Provider Match Program:** As specified in the Cardholder Agreement, no third party statement is required to be submitted to the Claims Administrator if the electronic claim file is accompanied by an electronic or written confirmation from the health care provider (e.g., your prescription benefits manager) that identifies the nature of your expense and verifies the amount.

Note: You should still obtain the third party receipt when you incur the expense and swipe the card, even if you think it will not be needed, so that you will have it in the event the Claims Administrator does request it.

(h) *You must pay back any improperly paid claims.* If you are unable to provide adequate or timely substantiation as requested by the Claims Administrator, you must repay the Plan for the unsubstantiated expense. The deadline for repaying the Plan is set forth in the Cardholder Agreement. If you do not repay the Plan within the applicable time period, the card will be turned off and an amount equal to the unsubstantiated expense will be offset against future eligible claims under the Health FSA.

(i) *You can use either the payment card or the traditional paper claims approach.* You have the choice as to how to submit your eligible claims. If you elect not to use the electronic payment card, you may also submit claims under the Traditional Paper Claims approach discussed above. Claims for which the Electronic Payment Card has been used cannot be submitted as Traditional Paper Claims.

DENIED CLAIM

If your claim for benefits is denied, you will have the right to a full and fair review process. Please refer to Appendix I for a detailed summary of the Claims Procedures under this Plan.

UNCLAIMED HEALTH CARE REIMBURSEMENTS

If the Eligible Medical Expenses you incur during the *Plan Year* are less than the annual amount you have elected for Health Care Reimbursement, you will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Eligible Medical Expenses you have incurred and the annual coverage level you have elected. Any amount allocated to a Health Care Account will be forfeited by the *Participant* and restored to the *Employer* if it has not been applied to provide reimbursement for expenses incurred during the *Plan Year* that are submitted for reimbursement within the Run Out Period. Amounts so forfeited shall be used to offset administrative expenses and future costs, and/or applied in a manner that is consistent with applicable rules and regulations (per the *Plan Administrator*'s sole discretion).

Any Health Care Reimbursement benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the *Plan Year* following the *Plan Year* in which the Eligible Medical Expense was incurred shall be forfeited.

COBRA CONTINUATION OF COVERAGE

The COBRA Administrator for the Commonwealth of Kentucky Health Flexible Spending Account is:

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

Federal law requires most private and governmental *employer*s sponsoring group health plans to offer *employees* and their families the opportunity for a temporary extension of health care coverage (called "continuation coverage") at group rates in certain instances where coverage under the plans would otherwise end. These rules are intended to summarize the continuation rights set forth under federal law. If federal law changes, only the rights provided under applicable federal law will apply. To the extent that any greater rights are set forth herein, they shall not apply.

When Coverage May Be Continued

Only "Qualified Beneficiaries" are eligible to elect continuation coverage if they lose coverage as a result of a *Qualifying Event*. A "Qualified Beneficiary" is the *Participant*, covered *Spouse* and/or covered dependent child at the time of the *qualifying event*.

A Qualified Beneficiary has the right to continue coverage if he or she loses coverage as a result of certain *qualifying event*s. The table below describes the *qualifying event*s that may entitle a Qualified Beneficiary to continuation coverage:

	Covered Employee	Covered Spouse	Covered Dependent
1. Covered Employee's Termination of employment or reduction in hours of employment	√	√	√
2. Divorce or Legal Separation		√	
3. Child ceasing to be an eligible dependent			√
4. Death of the covered employee		√	√

HEALTH FSA CONTINUATION OF COVERAGE (continued)

Type of Continuation Coverage

If you choose continuation coverage, you may continue the level of coverage you had in effect immediately preceding the *qualifying event*. However, if Plan benefits are modified for similarly situated active *employees*, then they will be modified for you and other Qualified Beneficiaries as well. After electing COBRA coverage, you will be eligible to make a change in your benefit election with respect to the Health FSA upon the occurrence of any event that permits a similarly situated active *employee* to make a benefit election change during a *Plan Year*.

If you do not choose continuation coverage, your coverage under the Health FSA will end with the date you would otherwise lose coverage.

Notice Requirements

You or your covered Dependents (including your *Spouse*) must notify your Insurance Coordinator in writing of a divorce, legal separation, or a child losing dependent status under the Plan. Your Insurance Coordinator will notify the COBRA Administrator, who in turn, will notify you that you have the right to choose continuation coverage by sending you the appropriate election forms. Notice to an employee's Spouse is treated as notice to any covered Dependents who reside with the Spouse.

An *employee* or covered Dependent is responsible for notifying the COBRA Administrator if he or she becomes covered under another group health plan.

Election Procedures and Deadlines

Each qualified beneficiary is entitled to make a separate election for continuation coverage under the Plan if they are not otherwise covered as a result of another Qualified Beneficiary's election. In order to elect continuation coverage, you must complete the Election Form(s) within 60 days from the date you would lose coverage for one of the reasons described above or the date you are sent notice of your right to elect continuation coverage, whichever is later. Failure to return the election form within the 60-day period will be considered a waiver of your continuation coverage rights.

HEALTH FSA CONTINUATION OF COVERAGE (continued)

Cost

You will have to pay the entire cost of your continuation coverage. The cost of your continuation coverage will not exceed 102% of the applicable premium for the period of continuation coverage. The first contribution after electing continuation coverage will be due 45 days after you make your election. Subsequent contributions are due the 1st day of each month; however, you have a 30-day grace period following the due date in which to make your contribution. Failure to make contributions within this time period will result in automatic termination of your continuation coverage.

When Continuation Coverage Ends

The maximum period for which coverage may be continued is the end of the *Plan Year* in which the *qualifying event* occurs. Continuation coverage may end earlier for any of the following reasons:

- if the contribution for your continuation coverage is not paid on time or it is significantly insufficient (Note: if your payment is insufficient by the lesser of 10% of the required premium, or $50, you will be given 30 days to cure the shortfall);
- if you become covered under another group health plan and are not actually subject to a pre-existing condition exclusion limitation;
- if you become entitled to Medicare; or
- if the *employer* no longer provides group health coverage to any of its *employees*.

APPENDIX I

CLAIMS REVIEW PROCEDURE CHART

The *Effective Date* of this Appendix I is January 1, 2006. It should replace and supersede any other Appendix I with an earlier date. The Plan has established the following claims review procedure in the event you are denied a benefit under this Plan.

Step 1: *Notice is received from Third Party Administrator*. If your claim is denied, you will receive written notice from the Third Party Administrator that your claim is denied as soon as reasonably possible but no later than 30 days after receipt of the claim. For reasons beyond the control of the Third Party Administrator, the Third Party Administrator may take up to an additional 15 days to review your claim. You will be provided written notice of the need for additional time prior to the end of the 30-day period. If the reason for the additional time is that you need to provide additional information, you will have 45 days from the notice of the extension to obtain that information. The time period during which the Third Party Administrator must make a decision will be suspended until the earlier of the date that you provide the information or the end of the 45-day period.

Step 2: *Review your notice carefully*. Once you have received your notice from the Third Party Administrator, review it carefully. The notice will contain:

a. the reason(s) for the denial and the Plan provisions on which the denial is based;
b. a description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
c. a description of the Plan's appeal procedures and the time limits applicable to such procedures; and
d. a right to request all documentation relevant to your claim.

Step 3: *If you disagree with the decision, file an Appeal.* If you do not agree with the decision of the Third Party Administrator and you wish to appeal, you must file your appeal no later than 180 days after receipt of the notice described in Step 1. You should submit all information identified in the notice of denial as necessary to perfect your claim and any additional information that you believe would support your claim.

Step 4: *Notice of Denial is received from Third Party Administrator*. If the claim is again denied, you will be notified in writing as soon as possible but no later than 30 days after receipt of the appeal by the Third Party Administrator.

Step 5: *Review your notice carefully.* You should take the same action that you took in Step 2 described above. The notice will contain the same type of information that is provided in the first notice of denial provided by the Third Party Administrator.

APPENDIX I (continued)

Step 6: *If you still disagree with the Third Party Administrator's decision, file a 2nd Level Appeal with the Plan Administrator.* If you still do not agree with the Third Party Administrator's decision and you wish to appeal, you must file a written appeal with the *Plan Administrator* within the time period set forth in the first level appeal denial notice from the Third Party Administrator. You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe would support your claim.

If the *Plan Administrator* denies your 2nd Level Appeal, you will receive notice within 30 days after the *Plan Administrator* receives your claim. The notice will contain the same type of information that was referenced in Step 1 above.

Other important information regarding your appeals:

- Each level of appeal will be independent from the previous level (i.e., the same person(s) or subordinates of the same person(s) involved in a prior level of appeal will not be involved in the appeal);
- On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information; and
- You cannot pursue other legal remedies until you have exhausted these appeals procedures.

APPENDIX II

QUALIFYING EVENT CHART

This chart reflects the mid-year election changes permitted in health insurance for the entire group and the changes permitted in the Health FSA and Dependent Care FSA for Commonwealth Choice participants.

This chart describes the election changes that a cafeteria plan can permit employees to make during a period of coverage under the final cafeteria plan regulations issued in March 2000 and January 2001. Although some of the regulatory provisions are ambiguous, this chart reflects our views of permitted election changes, which are adopted for the Plan Year 2006 and each Plan Year thereafter unless amended. The only required mid-year election changes are those related to loss of eligibility (death, divorce, loss of dependency and age.)

Event	Commonwealth Choice Health FSA Covering Expenses of Employee, Spouse, Dependents	Commonwealth Choice Dependent Care FSA
Change in Legal Marital Status		
Marriage	Start or increase election or Decrease election if family members become covered under spouse's health plan (2)	Start or increase election if marriage increases dependent care expenses (3) or stop or decrease election if family elects dependent care assistance under spouse's plan or marriage decreases dependent care expenses (3)
Divorce, legal separation, annulment	Start or increase election if event causes loss of coverage under spouse's health plan (2) or Stop election and redirect the state contribution to health insurance if the event causes loss of other coverage for the employee or Decrease election	Start or increase election if event increases dependent care expenses (3) or causes loss of coverage under spouse's plan or Stop or decrease election if event decreases dependent care expenses (3)

Event	Commonwealth Choice Health FSA Covering Expenses of Employee, Spouse, Dependents	Commonwealth Choice Dependent Care FSA
Spouse's death	Start or increase election if death causes loss of coverage under spouse's health plan (2) or Stop election and redirect the state contribution to health insurance if the event causes loss of other coverage for the employee or Decrease election	Start or increase election if death causes loss of coverage under spouse's plan or increases dependent care expenses (3) or Stop or decrease election if death decreases dependent care expenses (3)
Change in Number of Dependents		
Number of employee's eligible dependents increases by the following: birth; adoption (10); and placement for adoption (10)	Start or increase election	Start or increase election if employee has greater dependent care expenses
Number of employee's eligible dependents decreases (e.g., by death or because child becomes ineligible)	Decrease election	Stop or decrease election if employee has reduced dependent care expenses
Change in Employee's Employment Status		
Employee terminates employment	Cease contributions	Cease contributions

Event	Commonwealth Choice Health FSA Covering Expenses of Employee, Spouse, Dependents	Commonwealth Choice Dependent Care FSA
Employee is rehired less than 30-days after termination of employment	Reinstate prior election unless intervening status change event* If employee did not elect COBRA during termination period, reinstatement of the prior coverage can be accomplished with one of the following methods (employee's choice): Proration: Employee may elect to continue at the same monthly contribution as prior to the termination and the annual amount is reduced by the contributions missed during that period or Reinstatement: Employee may elect to makeup the shortfall resulting from the contributions missed during the termination period	Reinstate prior election unless intervening status change event*
Employee is rehired more than 30-days after termination of employment	Make election to same extent permitted as a new employee	Make election to same extent permitted as new employee
Employee commences official leave without pay	Cease contributions	Cease contributions

Event	Commonwealth Choice Health FSA Covering Expenses of Employee, Spouse, Dependents	Commonwealth Choice Dependent Care FSA
Employee returns from official leave without pay	Reinstate prior election unless intervening status change event (9) Reinstatement of the prior coverage can be accomplished with one of the following methods (employee's choice): Proration: Employee may elect to continue at the same monthly contribution as prior to the termination and the annual amount is reduced by the contributions missed during that period or Reinstatement: Employee may elect to makeup the shortfall resulting from the contributions missed during the terminated period	Reinstate prior election or Change election if event changes dependent care expenses (3)
Employee begins unpaid FMLA leave (4) or Military Leave *NOTE: Employee may choose not to participate; otherwise they must choose one payment option or another	Cease contributions or Prepayment: Increase election to prepay coverage during leave or Pay-as-you-go: Employee may make contributions on the same schedule as payments would have been made otherwise	Decrease election if leave causes loss of coverage or decreases dependent care expenses (3) or Cease contributions

Event	Commonwealth Choice Health FSA Covering Expenses of Employee, Spouse, Dependents	Commonwealth Choice Dependent Care FSA
Employee returns from unpaid FMLA leave (4) or Military Leave	Employee must be able to reinstate prior coverage and can choose one of the following: Proration: Employee may elect to continue at the same monthly contribution as prior to the FMLA and the annual amount is reduced by the contributions missed during the FMLA or Reinstatement: Employee may elect to makeup the shortfall resulting from the contributions missed during FMLA	Generally same rights as employee returning from non-FMLA leave, though employee must be able to reinstate prior coverage
Employee commences paid leave (assuming event does not affect eligibility for coverage)	No change	Decrease election if event decreases dependent care expenses (3)
Employee returns from paid leave	No change	Increase election if event increases dependent care expenses (3)
Employee changes worksite	No change	Decrease election if event decreases dependent care expenses (3) or Increase election if event increases dependent care expenses (3) (unless the care provider is a relative)

Event	Commonwealth Choice Health FSA Covering Expenses of Employee, Spouse, Dependents	Commonwealth Choice Dependent Care FSA
Other change in employee's employment status (e.g., switch from salaried to hourly status) that causes employee to cease eligibility under plan	Cease contributions	Cease contributions
Other change in employee's employment status (e.g., switch from hourly to salaried status) that causes employee to become eligible for coverage under plan	Make elections as if a new employee unless there was less than 30-day break in employment	Make elections as if a new employee unless there was less than a 30-day break in employment
Change in Spouse or Dependent Employment Status (Dependent must continue to meet all eligibility requirements.)		
Spouse or dependent terminates employment	Start or increase election if event adversely affects eligibility for coverage under spouse's or dependent's health plan (2)	Start or increase election if event adversely affects eligibility for coverage under spouse's dependent care assistance plan or Stop or decrease election if event decreases dependent care expenses (3)
Spouse or dependent commences employment	Decrease election if family becomes covered under health plan of spouse or dependent (2)	Start or increase election if event increases dependent care expenses (3) or Stop or decrease election if family becomes covered under spouse's dependent care assistance plan

Event	Commonwealth Choice Health FSA Covering Expenses of Employee, Spouse, Dependents	Commonwealth Choice Dependent Care FSA
Spouse or dependent is out of work due to strike or lockout	Start or increase election if event adversely affects eligibility for coverage under spouse's or dependent's health plan (2)	Start or increase election if event adversely affects eligibility for coverage under spouse's dependent care assistance plan or Stop or decrease election if event decreases dependent care expenses (3)
Spouse or dependent returns to work following cessation of strike or lockout	Decrease election if family becomes covered under health plan of spouse or dependent (2)	Start or increase election if event increases dependent care expenses (3) or Stop or decrease election if family becomes covered under spouse's dependent care assistance plan
Spouse or dependent commences unpaid leave (if the event adversely affects eligibility for coverage under the spouse or dependent's plan)	Start or increase election if event adversely affects eligibility for coverage under spouse's or dependent's health plan (2)	Start or increase election if event adversely affects eligibility for coverage under spouse's dependent care assistance plan or Stop or decrease election if event decreases dependent care expenses (3)
Spouse or dependent returns from unpaid leave	Decrease election if family becomes covered under spouse's or dependent's health plan (2)	Start or increase election if event increases dependent care expenses (3) or Stop or decrease election if family becomes covered under spouse's dependent care assistance plan

Event	Commonwealth Choice Health FSA Covering Expenses of Employee, Spouse, Dependents	Commonwealth Choice Dependent Care FSA
Other change in spouse's or dependent's employment status that causes spouse or dependent to cease to be eligible for coverage under spouse's or dependent's plan (e.g., switch from salaried to hourly status)	Start or increase election (2)	Start or increase election if event adversely affects eligibility for coverage under spouse's plan (3)
Other change in employment status that causes spouse or dependent to gain eligibility for coverage under spouse's or dependent's plan (e.g., switch from hourly to salaried status)	Decrease election if family members become covered under health plan of spouse or dependent (2)	Decrease election or Increase election if event increases dependent care expenses (3)
Change in Dependent Eligibility		
Dependent ceases to satisfy plan eligibility requirements on account of age, marriage or any similar circumstance (support and maintenance)	Decrease election	Stop or decrease election if event decreases dependent care expenses (3)
Unmarried dependent re-establishes plan eligibility requirement (5) under applicable plan	Start or increase election	Start or increase election if event increases dependent care expenses (3)
Change in Residence		
Employee or spouse changes primary (6) residence and becomes ineligible for current benefit election	No Change	Make a corresponding election change if the child care provider changes
Other Events		

Event	Commonwealth Choice Health FSA Covering Expenses of Employee, Spouse, Dependents	Commonwealth Choice Dependent Care FSA
Loss of other group health insurance coverage or health insurance coverage that entitles employee or family member to be enrolled under HIPAA Special Enrollment Rights	Start or increase election or Stop election and redirect the state contribution if the event causes loss of other coverage for the employee or Start or increase election	None
Judgment, decree, or administrative order relating to health coverage for child	Start or increase election if order requires employee to provide child's health coverage or Decrease election if other parent covers child under order	None
Employee, spouse, or dependent enrolled in employer's health plan becomes entitled to Medicare or Medicaid	Decrease election	None
Employee, spouse, or dependent loses entitlement to Medicare, Medicaid, KCHIP, any governmental group health insurance coverage	Start or increase election	None
Cost or Coverage Changes (8)		
Change in Cost		
Benefit option has significant increase or decrease in cost		Make a corresponding change (increase or decrease). Increasing the election for a day care provider raising rates mid-year is only permitted if the provider is not a relative of the employee.

Event	Commonwealth Choice Health FSA Covering Expenses of Employee, Spouse, Dependents	Commonwealth Choice Dependent Care FSA
Change In Coverage Under Another Employer Plan		
Employee's spouse makes elections during an open enrollment period that differs from the open enrollment period of the employer (7)	After Open Enrollment and before 12/31 Employee may make corresponding change (and redirect state contribution) After 12/31 - None	Employee can make election change that "corresponds" with election change under the other employer plan
Employee makes elections during an open enrollment period of another employer that differs from the open enrollment period of the employer (7)	After Open Enrollment and before 12/31 Employee may make corresponding change (and redirect state contribution) After 12/31 – None	
Retiree makes elections during an open enrollment period of a state sponsored retirement system that differs from the open enrollment period of the employer	None	
Individual changes election for any other event that is permitted under regulation (and terms of the employer plan)	None	Employee can make election change that "corresponds" with election change

Permitted Election Changes

End Notes:

(1) The final regulation preamble indicates that dependents who can be added are those who were directly affected by the status change event plus other dependents (the so-called "tag-along" rule). However, the examples in the regulation only explicitly deal with situations where an employee elects family coverage and adds family members at no additional cost. It is not clear, but IRS staff members have informally stated that the "tag-along" rule applies even if the employee must increase an election to add additional dependents. Also, the preamble and examples in the regulation indicate that the "tag-along" rule applies to HIPAA events and situations where a spouse terminates employment; it is not clear what other events might be covered by the "tag-along" rule.

(2) It appears this rule does not require that a spouse's coverage include a Health FSA.

(3) By an increase or decrease in dependent care expenses, we mean that the event increases or decreases the amount of expenses that an employee can have reimbursed on a tax-free basis under Code section 129 from a dependent care assistance plan. For example, if the employee gets married and his or her spouse does not work outside the home, the spouse would be available to care for a child, and thus the employee may not be able to claim that dependent care expenses are being used to enable the employee to be gainfully employed — a condition that must be satisfied for the expense to be reimbursed on a tax-free basis under Code section 129. Conversely, the marriage can increase the amount of expenses reimbursable under the dependent care assistance plan if, for example, a new spouse or stepchild is a "qualifying individual" for whom dependent care assistance can be received. A spouse's death or divorce might lead to fewer dependent care expenses eligible for reimbursement under section 129 if, for example, the spouse was a "qualifying individual." Conversely, if the spouse was not employed outside the home, the death or divorce might require the employee to pay for a caregiver in order to remain gainfully employed, and therefore the expenses may be reimbursed on a tax-free basis under section 129.

(4) Most employees are entitled to certain rights under the Family and Medical Leave Act (FMLA), whether or not the benefits are provided through a cafeteria plan. Employees generally must receive up to 12 weeks of unpaid FMLA leave, although the employee or employer generally can choose to substitute available paid leave for unpaid leave. During FMLA leave, the employer must maintain group health coverage (including FSA coverage) on the same conditions as coverage would be provided if the employee had not taken the leave. An employee's entitlement to other benefits during FMLA leave is determined by the employer's established policy for providing such benefits when the employee is on other forms of paid or unpaid leave (as appropriate).

If benefits are continued during unpaid leave, proposed IRS regulations allow benefits purchased through a cafeteria plan to be paid in several ways, including increased salary reductions before the leave to prepay benefits or using salary reductions after the leave to "catch-up" on payments. Benefits continued on paid FMLA leave are paid for in the same manner as during any paid leave. Employees can choose to drop benefits while on leave, but FMLA requires they have the right to be reinstated upon return from leave.

(5) For purposes of eligibility in this plan, a divorced dependent is not an "unmarried" dependent.

(6) Primary residence is the official residence claimed for tax purposes.

(7) Military Insurance Coverage, which does not include Veteran's Administration benefits, is considered "Another Employer Plan".

(8) "Cost or Coverage Changes under the Employer's Plan" are not included in this chart. In the event there is a mid-year change in the health plan, specific direction will be provided to the group or groups affected.

(9) An employee must request the mid-year election change within 30 days of the return to work date.

(10) Supporting documentation required.

(11) HIPAA Special Enrollment Right

(12) Qualifying Event permits change in plan option (Essential, Enhanced, or Premier).

Effective Dates:
Effective dates for the various mid-year election changes are as follows:

A. Events increasing coverage
   1. Birth, adoption, placement for adoption = date of the event;
   2. Marriage, loss of other coverage, court or administrative orders for dependent(s) or foster child(ren), expiration of COBRA = 1st day 1st month from the employee signature date.
   3. Different Open Enrollment = 1st day 1st of month (match effective date of other employer's plan)

B. Events decreasing coverage
   1. Death = date of the event.
      a. death of the employee with dependents = end of month in which death occurred
      b. death of employee no dependents = date of death
      c. death of dependent = date of death
   2. Divorce, loss of dependent status = End of the month of loss of eligibility.
   3. Gaining other health insurance coverage (Medicare/Medicaid/Tricare/etc.) = End of the month from the employee's signature date.
   4. Different Open Enrollment = Last day of the month (match other employer's plan).

All Qualifying Events must be signed by the employee 30-days from the date of the Qualifying Event, except for birth, adoption, or placement for adoption when adding the newly acquired dependent only, which is 60-days. However, if the Qualifying Event is loss of other coverage, the employee is permitted to sign the Qualifying Event prior to the Qualifying Event date.

Note: The effective dates for the specific Qualifying Events listed below are different from those included as part of the preceding Qualifying Event Chart. The following effective dates are only applicable to Health Care and Dependent Care Flexible Spending Accounts.

A. Events increasing coverage
   1. Birth, adoption, placement for adoption = 1st day of 1st month from the employee's signature date

B. Events decreasing coverage
   1. Death = date of death
      a. death of the employee with dependents = date of death

APPENDIX III

ELIGIBLE CLAIMS EXPENSES

Note: This is only a list of examples. The IRS could allow or disallow items depending on facts or circumstances. For a complete listing on non-reimbursed qualified expenses, refer to Internal Revenue Service (IRS) Publication 502. This publication is available at your public library or from the IRS.

Prescription Drugs:

- Allowable Expenses
  - Prescription drugs or insulin
  - Birth control drugs (prescribed)
- Specifically Disallowed
  - Nonprescription drugs, vitamins or illegal drugs

Medical Equipment:

- Allowable Expenses
  - Wheelchair or automate (cost of operating/maintaining)
  - Crutches (purchased or rented)
  - Special mattress and plywood boards prescribed to alleviate arthritis
  - Oxygen equipment and oxygen used to relieve breathing problems that result from a medical condition
  - Artificial limbs
  - Support hose (if medically necessary)
  - Wigs (where necessary for mental health or individual who loses hair because of disease)
  - Excess cost of orthopedic shoes over the cost of ordinary shoes
- Specifically Disallowed
  - Wigs, when not medically necessary for mental health
  - Vacuum cleaner purchased by an individual with dust allergy

Treatments and Therapies

- Allowable Expenses
  - X-ray treatments
  - Treatment for alcoholism or drug dependency
  - Acupuncture
  - Vaccinations
  - Physical therapy (as a medical treatment)
  - Speech therapy
- Specifically Disallowed
  - Physical treatments unrelated to specific health problem (e.g., massage for general well-being)
  - Stop smoking programs for general well-being
  - Any illegal treatment

Vision Care:

- Allowable Expenses
  - Optometrist's or ophthalmologist's fees
  - Eyeglasses
  - Contact lenses and cleaning solutions
  - LASIK and other surgical procedures
- Specifically Disallowed
  - Lens replacement insurance

Hearing Care:

- Allowable Expenses
  - Hearing aids
  - Batteries for operation of hearing aids

Psychiatric Care:

- Allowable Expenses
  - Services of psychotherapists, psychiatrists, and psychologists
  - Psychiatric therapy for sexual problems
  - Legal fees directly related to commitment of a mentally ill person
- Specifically Disallowed
  - Psychoanalysis undertaken to satisfy curriculum requirements of a student

Physicals:

- Allowable Expenses
  - Routine and preventive physicals
  - School and work physicals

Fees/Services:

- Allowable Expenses
  - Physician's fees
  - Obstetrical expenses
  - Hospital services
  - Nursing services for care of a specific medical ailment
  - Cost of a nurse's room and board when nurse's services qualify
  - The Social Security tax paid with respect to wages of a nurse when nurse's services qualify
  - Surgical or diagnostic services
  - Legal sterilization
  - Cosmetic surgery or procedures that treat a deformity caused by an accident or trauma, disease or an abnormality at birth
  - Services of chiropractors and osteopaths
  - Anesthesiologist's fees
  - Dermatologist's fees
  - Christian Science practitioner fees
- Specifically Disallowed
  - Cosmetic surgery or procedures that improve the patient's appearance but do not meaningfully promote the proper function of the body or prevent or treat an illness or a disease
  - Payments to domestic help, companion, baby-sitter, chauffeur, etc., who primarily renders services of a non-medical nature
  - Nursemaids or practical nurses who render general care for healthy infants
  - Fees for exercise, athletic, or health club membership, when there is no specific health reason for membership
  - Payments for child care
  - Marriage counseling provided by a member of the clergy

Assistance for the Handicapped:

- Allowable Expenses
  - Cost of guide for a blind person
  - Cost of note-taker for a deaf child in school
  - Cost of Braille books and magazines in excess of cost of regular editions
  - Seeing eye dog (cost of buying, training , and maintaining)
  - Hearing-trained cat or other animal to assist deaf person (cost of buying, training, and maintaining)

- Household visual alert system for deaf person
- Excess cost of specifically equipping automobile for handicapped person over the cost of ordinary automobile; device for lifting handicapped person into automobile
- Special devices, such as tape recorder and typewriter, for a blind person

Dental and Orthodontic Care:

- Allowable Expenses
  - Dental care
  - Artificial teeth/Dentures
  - Cost of fluoridation of home water supply advised by dentist
  - Braces, orthodontic services
- Specifically Disallowed
  - Teeth bleaching
  - Tooth bonding that is not medically necessary

Miscellaneous Charges:

- Allowable Expenses
  - X-rays
  - Expenses of services connected with donating an organ
  - Cost of computer storage of medical records
  - Cost of special diet, but only if it is medically necessary and only to the extent that costs exceed that of a normal diet
  - Transportation expenses primarily for, and essential to, medical care including bus, taxi, train, plane fares, ambulance services, parking fees, and tolls
  - Lodging expenses (not provided in a hospital or similar institution) while away from home if all of the following requirements are met:
    - Lodging is primarily for and essential to medical care.
    - Medical care is provided by a doctor in a licensed hospital or in a medical care facility related to, or the equivalent of, a licensed hospital.
    - Lodging is not lavish or extravagant under the circumstances.
    - There is no significant element of personal pleasure, recreation, or vacation in the travel away from home. The amount included in medical expensed cannot exceed $50 for each night for each person. Lodging is included for a person for whom transportation expenses are a medical expense because that person is traveling with the person receiving medical care. For example, if a parent is traveling with a sick child, up to $100 per night is included as a medical expense for lodging (meals are not deductible).

- Amounts paid for meals during inpatient care at hospital or similar institution, if the main reason for being there is to receive medical care

- Specifically Disallowed
  - Expenses of divorce when doctor or psychiatrist recommends divorce
  - Cost of toiletries, cosmetics, and sundry items (e.g., soap, toothbrushes)
  - Cost of special foods taken as a substitute for regular diet, when the special diet is not medically necessary or cost is not in excess of a normal diet
  - Weight loss maintenance programs
  - Maternity clothes
  - Diaper service
  - Distilled water purchased to avoid drinking fluoridated city water supply
  - Installation of power steering in an automobile
  - Pajamas purchased to wear in hospital
  - Mobile telephone used for personal phone calls as well as calls to a physician
  - Insurance against loss of income, loss of life, limb or sight
  - Union dues for sick benefits for members
  - Contributions to state disability funds
  - Premiums paid for insurance coverage including auto insurance providing medical coverage
  - Capital expenditures (i.e. construction costs, elevators, swimming pool, or hot tub)

APPENDIX IV

DEFINITIONS

Affiliated Employer **-** means any entity who is considered with the Employer to be a single employer in accordance with Code Section 414(b), (c), or (m).

After-tax Contribution(s) **-** means amounts withheld from an Employee's *Compensation* after all applicable state and federal taxes have been deducted. Such amounts are withheld for purposes of purchasing one or more of the Benefit Package Options available under the Plan.

Benefit Package Option(s) **-** means those Qualified Benefits available to a Participant under this Plan as amended and/or restated from time to time.

Code **-** means the Internal Revenue Code of 1986, as amended.

Compensation **-** means the cash wages or salary paid to an Employee by the Employer.

Effective Date **-** This is the date the Plan was established.

Employee **-** means an individual who the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll, but does not include any of the following: (a) any leased employee (including, but not limited to, those individuals defined in *Code* § 414(n)); (b) an individual classified by the Employer as a contract worker or independent contractor; (c) an individual classified by the Employer as a temporary employee or casual employee, whether or not any such persons are on the Employer's W-2 payroll; and (d) any individual who performs services for the Employer but who is paid by a temporary or other employment agency such as "Kelly," "Manpower," etc., or any employee covered under a collective bargaining agreement, except as otherwise provided for in the collective bargaining agreement.

Employer **-** means the Commonwealth of Kentucky and any Affiliated Employer who adopts the Plan pursuant to authorization provided by the Employer. Affiliated Employers who adopt the Plan shall be bound by the Plan as adopted and subsequently amended unless they clearly withdraw from participation herein.

Highly Compensated Individual **-** means an individual defined under *Code* Section 125(e), as amended, as a "highly compensated individual" or a "highly compensated employee."

Key Employee **-** means an individual who is a "key employee" as defined in *Code* Section 125(b)(2), as amended.

Nonelective Contribution(s) **-** means any amount that the Employer, in its sole discretion, may contribute on behalf of each Participant to provide benefits for such Participant and his or her Dependents, if applicable, under one or more of the *Benefit Package Option*(s) offered under the Plan. The amount of employer contribution that is applied towards the cost of the *Benefit Package Option*(s) for each Participant and/or level of coverage shall be subject to the sole discretion of the Employer and may be adjusted upward or downward at any time in the contributing Employer's sole discretion. The amount shall be calculated for each Plan Year in a uniform and nondiscriminatory manner and may be based upon the Participant's dependent status, commencement, or termination date of the Participant's employment during the Plan Year, and such other factors as the Employer shall prescribe. In no event will any Nonelective Contribution be disbursed to a Participant in the form of additional, taxable *Compensation*.

Participant **-** means an Employee who becomes a Participant pursuant to this *Summary Plan Description*.

Plan **-** means this Cafeteria Plan, as set forth herein.

Plan Administrator **-** means the person(s) or Committee identified in the *Summary Plan Description* that is appointed by the Employer with authority, discretion, and responsibility to manage and direct the operation and administration of the Plan. If no such person is named, the Plan Administrator shall be the Employer.

Plan Year **-** shall be the period of coverage set forth in this *Summary Plan Description*.

Pre-tax Contribution(s) **-** means amounts withheld from an Employee's *Compensation* before any applicable state and federal taxes have been deducted. The amounts are withheld for purposes of purchasing one or more of the *Benefit Package Option*s available under the Plan. This amount shall not exceed the premiums or contributions attributable to the most costly *Benefit Package Option* afforded hereunder, and for purposes of *Code* Section 125, shall be treated as an Employer contribution (this amount may, however, be treated as an Employee contribution for purposes of state insurance laws).

Qualifying Event **-** means any of the events described in this *Summary Plan Description*, as well as any other events included under subsequent changes to *Code* Section 125 or regulations issued under *Code* Section 125, that the Plan Administrator (in its sole discretion) decides to recognize on a uniform and consistent basis as a reason to change the election mid-year. .

Run Out Period – is the period during which expenses incurred during a Plan Year must be submitted to be eligible for Reimbursement. The Run Out Period for active and terminated employees ends 90 days after the end of the Plan Year.

Spouse **-** means an individual who is legally married to a Participant (and who is treated as a spouse under the *Code*).

Summary Plan Description" or "SPD" **-** means the Flexible Benefits Plan SPD and all appendices incorporated into and made a part of the SPD that is adopted by the Employer and as amended from time to time. The SPD and appendices are incorporated hereto by reference.

Student **-** means an individual who, during each of five (5) or more calendar months during the Plan Year, is a full time student at any college or university, the primary function of which is the conduct of formal instruction, and which routinely maintains a regular faculty and curriculum and normally has an enrolled student body in attendance at the location where its educational activities are regularly presented.