COMMONWEALTH OF KENTUCKY

SUMMARY PLAN DESCRIPTION

COMMONWEALTH OF KENTUCKY HEALTH REIMBURSEMENT ACCOUNT WAIVERS ONLY

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

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

Any changes in the HRA, 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 HRA or promise having the same effect, made by any person will not be binding with respect to the HRA.

Louisville Plan Number: 239480

Lexington Plan Number: 239832

Northern Kentucky Plan Number: 240042

Effective Date: January 1, 2008

Plan Year: January 1, 2008 through December 31, 2008

Employer's Federal Tax Identification Number: 61-0600439

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PLAN INFORMATION

GENERAL INFORMATION ABOUT THE PLAN

The Commonwealth of Kentucky (the "*Employer*") has established the Commonwealth of Kentucky Health Reimbursement Account (the "HRA"). The purpose of this HRA is to reimburse *Participants* for certain unreimbursed medical expenses ("HRA Eligible Medical Expenses") incurred by the Participant and their eligible dependents. This HRA is intended to qualify as a self-insured medical reimbursement plan for purposes of Section 105 and 106 of the Internal Revenue Code ("Code").

Each summary and the attached Appendices constitute the *Summary Plan Description* for the Commonwealth of Kentucky Health Reimbursement 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 HRA, you should contact the Third Party Administrator or the *Plan Administrato*r.

Employer / Plan Sponsor

Commonwealth of Kentucky
Personnel Cabinet, Department for Employee Insurance
501 High Street
Second Floor
Frankfort, KY 40601
502-564-0350
502-564-0351

PLAN INFORMATION (continued)

Plan Administrator

Commonwealth of Kentucky
Personnel Cabinet, Department for Employee Insurance
501 High Street
Second Floor
Frankfort, KY 40601
502-564-0350
502-564-0351

Third Party Administrator

Humana
Attn: Humana Spending Account Administration Team
PO Box 3967
Louisville KY 40201-3967
Toll Free: 1-800-604-6228
Fax: 1-800-905-1851

ELIGIBILITY REQUIREMENTS

PARTICIPATION

You are eligible to participate in this HRA if you satisfy the below Eligibility Requirements. Eligible *employees* who become covered under this HRA are called "*Participants.*"

"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.

While you are an active employee, only the *Employer* contributes to your Health Reimbursement Account (with HRA dollars). In fact, federal laws prohibit you from contributing to your Health Reimbursement Account with any portion of a pre-tax salary reduction made under a Code Section 125 cafeteria plan. You may, however, be required to pay the "applicable premium" for continuation of HRA coverage under COBRA.

ENROLLMENT

Once you become a Participant, the *Employer* establishes a Health Reimbursement Account for you. The Health Reimbursement Account is a notional bookkeeping account that keeps a record of HRA dollars allocated to your account and reimbursements made to you under this HRA. You have no property rights to the Health Reimbursement Account. Coverage under this HRA for an Eligible Employee and Eligible Dependent(s) begins on January 1, 2008. In no event will the coverage under this HRA begin before the *effective date* of this HRA.

If eligible, e*mployees* who waive health insurance coverage will receive *Employer* Health Reimbursement Account contributions. The Commonwealth of Kentucky will contribute $175 per month for each employee who waives medical coverage. This will total $2,100 for the year.

ELIGIBLE DEPENDENTS

An eligible dependent is a dependent who meets all of the qualifications of a dependent as determined by Section 152 of the Internal Revenue Code.

Unmarried dependent child: An unmarried dependent child is a member's blood child, stepchild, adopted/placed child, foster child or grandchild, who meets the following **eligibility rules:**

- lives with the member for more than half of the calendar year;
- does not provide over one-half of his/her own support during the calendar year; and
- is less than 24 years of age at the end of the NEXT calendar year;

Temporary absences, such as for school, are permitted.

ELIGIBILITY REQUIREMENTS (continued)

A dependent child who does not live with the member, but for whom the member or his/her spouse has a legal obligation under a divorce decree, court order or administrative order to provide for the health care expenses of the child, remains eligible for coverage under the Plan.

A foster child must have been placed by an authorized agency or by judgment, decree or court order.

A grandchild meets the above eligibility rules only when the member has guardianship or custody papers.

Age restrictions do not apply to a child that is permanently and totally disabled.

An unmarried disabled dependent may continue to be covered under the Plan beyond the age limit specified under the eligibility rules if the disability started before the limiting age and is medically certified by a physician.

A total disability is defined as the condition that results when any medically determinable physical or mental condition prevents a dependent from engaging in substantial gainful activity and can be expected to result in death or to be of a continuous or indefinite duration. The KEHP's Third Party Administrator may require proof of the dependent's disability at least annually.

A disabled dependent not covered under the Plan prior to the limiting age may only be enrolled in the Plan if he/she **loses** other health insurance coverage.

If, during Open Enrollment, you wish to enroll a disabled dependent that is past the limiting age specified under the eligibility rules, you must show proof that the disabled dependent has experienced a loss of coverage. The request to add the disabled dependent must be made within thirty (30) calendar days of the qualifying event (QE).

Working Families Tax Relief Act (WFTRA) of 2004

In the Working Families Tax Relief Act (WFTRA) of 2004 (I.R.C. § 152), Congress changed the way the Internal Revenue Service treats children under the tax code.

The WFTRA of 2004 developed a new definition for "qualified child" and "qualified relative." An employee will NOT be able to pay dependent premiums on a pre-tax basis if the employee's dependent(s) CANNOT MEET ONE of these definitions (qualifying child or qualifying relative). In nearly all circumstances, if the dependent meets KEHP eligibility criteria, they will also meet one of these federal definitions. **The KEHP dependent eligibility rules shall always be met before a dependent can be enrolled.**

ELIGIBILITY REQUIREMENTS (continued)

Pursuant to I.R.C. § 152, the new definitions are as follows:

A "qualifying child" (QC) is a child who:

- has a specific, family-type relationship to the member-taxpayer.
- resides with the member in his/her household for more than half of the tax year (with certain exceptions such as "temporary absences" if a full-time student).
- is under age 19 and not a full-time student (or under age 24 if a full-time student) as of the end of the calendar year in which the member's taxable year begins.

There is no age requirement if a child is permanently and totally disabled.

- has not provided more than half of his/her own support. The member-taxpayer no longer has to provide over half of the dependent-child's support for the tax year, unless s/he is a full-time student.

A "qualifying relative" (QR) is a child or other individual who:

- has a specific, family-type relationship to the member-taxpayer, and is someone who resides with the employee in his/her household for the member's taxable year.

A person cannot be a "qualifying relative" of the member if at any time during the taxable year the relationship between the member and the person violates federal, state, or local law.

- receives over half of his/her own support from the member-taxpayer.
- is not anyone's (including the member's) "qualifying child."

IMPORTANT: I.R.C. § 152 does not change KEHP's eligibility rules. It does not create any new category of eligible dependents, or make people who were previously ineligible for coverage now eligible. It simply redefines the way the IRS treats dependent children age 24 and over for tax purposes only. A dependent shall meet KEHP's eligibility rules before an employee may add the dependent to the Plan. **Adding a dependent to the Plan who does not meet the KEHP eligibility rules may be considered insurance fraud.**

REDIRECTION OF EMPLOYER CONTRIBUTION

A *Participant* may be eligible to redirect the employer contribution as stated in Appendix II.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

Special rule for leaves of absence due to services in the Uniformed Services:

If a covered employee takes a leave of absence to perform services in the Uniformed Services (as addressed in the Uniformed Services Employment and Reemployment Rights Act or "USERRA") that is expected to last 31 days or more, the covered employee may be able to continue health coverage for the employee and any Eligible Dependents until the earlier of 24 months from the date the leave began or the date that the employee fails to return to work as required under USERRA or otherwise lose his/her rights under USERRA). The cost to continue this coverage during the 24 month period is 102% of the applicable premium. The USERRA continuation period will run concurrent with the COBRA period described in this *SPD*. The COBRA rights described in this *SPD* apply only to the COBRA continuation period. Notwithstanding anything to the contrary in this *SPD*, continuation of coverage during a military leave of absence covered under USERRA will be administered in accordance with requirements of USERRA and if greater rights are inadvertently provided in this *SPD*, the terms of USERRA will control.

TERMINATION OF COVERAGE

Participation in the HRA ends on the day employment terminates or the day the employee becomes ineligible for participation, whichever comes first. However, you may be eligible to continue participation under this HRA in accordance with federal law beyond the date that participation would otherwise end. Your COBRA continuation rights and responsibilities are described in the Continuation of Coverage section. All HRA dollars that are not applied towards Eligible Medical Expenses incurred before your termination date are forfeited.

Although the *Employer* expects to maintain the HRA indefinitely, it has the right to modify or terminate the program at any time for any reason. All modifications/terminations effectuated by the *Employer* will be applied to all *Participants* except as otherwise stated.

REIMBURSEMENT

AVAILABLE FUNDS

Each *Plan Year*, the *Employer* allocates a specified amount of HRA dollars to your Health Reimbursement Account. The amount of HRA dollars allocated to your Health Reimbursement Account is determined at the sole discretion of the *Employer*. Nevertheless, the annual amount of HRA dollars allocated to each Participant's Health Reimbursement Account will be determined in a uniform and non-discriminatory manner in comparison to other similarly situated *employees*.

The Commonwealth of Kentucky Health Reimbursement Account does not contain a Maximum Account Balance. HRA dollars remaining in the Health Reimbursement Account at the end of the *Plan Year* will roll over to the next *Plan Year* if you re-enroll in the Commonwealth of Kentucky Health Reimbursement Account.

ELIGIBLE CLAIMS

Only medical care expenses that have not been or will not be reimbursed by any other source may be Eligible Medical Expenses (to the extent all other conditions for Eligible Medical Expenses have been satisfied). As such, this HRA does not coordinate benefits with any other group or individual health coverage except as provided herein.

"HRA Eligible Medical Expenses" are medical care expenses *incurred* by you or your eligible dependents that satisfy all of the conditions described below. All expenses that are not within the scope of "HRA Eligible Medical Expenses" described below are excluded. The following expenses are eligible for reimbursement under this HRA *Plan* (provided all other terms and conditions of the HRA have been satisfied):

Medical
Preventive Health Care
Prescriptions
Over the Counter Medications
Vision
Dental
Durable Medical Equipment

"Incurred" means the date the service or treatment is provided; not when the expense arising from the service or treatment is paid. Thus, an expense that has been paid but not incurred (e.g. pre-payment to a physician) will not be reimbursed until the services or treatment giving rise to the expense has been provided. In no event will the following expenses be eligible for reimbursement:

- Any expense that is not a Code Section 213(d) expense
- Any expenses incurred for qualified long term care services
- Expenses incurred prior to the date that coverage under this HRA becomes effective
- Expenses incurred after the date that coverage under this HRA ends
- Expenses that have been reimbursed by another plan or for which you plan to seek reimbursement under another health plan.

To the extent that Eligible Medical Expenses are covered both by this HRA and by an *Employer* administrated FSA in which the employee participates, Eligible Medical Expenses are first reimbursed from the FSA and then the HRA.

CLAIM REIMBURSEMENT

Under this HRA, 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 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

1. You can obtain a reimbursement form from the Third Party Administrator. You must complete the reimbursement form and submit it to the Third Party Administrator with an Explanation of Benefits ("EOB"). An EOB is a document provided by an insurer that explains the amounts, if any, paid under a Medical Plan. For information relating to the Third Party Administrator, please view the *Plan* Contact Information Section of this *SPD*. Forms can be mailed to P.O. Box 3967, Louisville, KY 40201 or faxed to 1-800-905-1851.

2. In some instances, your insurer (if Humana) may submit the EOB on your behalf. In that situation, you certify when you incur the expense that the expense has not been reimbursed by any other source and that you will not seek reimbursement from any other source. You may submit requests for reimbursement of Eligible Medical Expenses at any time prior to the end of the HRA Run Out Period. The HRA Run Out Period is 90 days after the end of the *plan year*. Requests for reimbursements submitted after the HRA Run Out Period will not be reimbursed.

3. Your HRA claim is deemed filed when it is received by the Third Party Administrator. If your claim for reimbursement is approved, you will be provided reimbursement as soon as reasonably possible following the determination. Any unclaimed reimbursement amounts (e.g., failing to cash a reimbursement check) will be forfeited and returned to the *Employer* if not claimed (or cashed) within 90 days of receipt.

4. If it is later determined that you and/or your eligible dependent(s) received an overpayment or a payment was made in error (e.g., you were reimbursed for an expense under the HRA that is later paid for by a Medical Plan, you will be required to refund the overpayment or erroneous reimbursement to the HRA.

REIMBURSEMENT (continued)

5. If you do not refund the overpayment or erroneous payment, the *Plan* reserves the right to offset future reimbursement equal to the overpayment or erroneous payment or, if that is not feasible, to withhold such funds from your pay. If all other attempts to recoup the overpayment/erroneous payment are unsuccessful, the *Plan Administrator* may treat the overpayment as a bad debt, which may have income tax implications for you. In addition, if the *Plan Administrator* determines that you have submitted a fraudulent claim, the *Plan Administrator* may terminate your coverage under this HRA.

Electronic Payment Card

The Electronic Payment Card allows you to pay for Eligible Medical Expenses at the time that you incur the expense.

1. 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 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 Cardholder Agreement is part of the terms and conditions of your *Plan* and this *SPD.*

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

3. 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 HRA 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.

4. HRA reimbursement under the card is limited to health care providers (including pharmacies). Use of the card for HRA expenses is limited to merchants who are health care providers (doctors, pharmacies, etc.). As set forth in the Cardholder Agreement, you will not be able to use the card at a regular retail store – e.g., a supermarket, grocery store, or discount store with a pharmacy.

REIMBURSEMENT (continued)

5. You swipe the card at the health care provider like you do any other credit 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 card. The provider is paid for the expense up to the maximum reimbursement amount available under the HRA (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 HRA 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.

6. 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).
   - If the expense is for an over the counter drug, the written statement must indicate the name of the drug.
   - 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, you may be required to submit a written third party statement (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.

7. 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.

Note: You should still obtain the third party receipt when you incur an expense and swipe the card, even if you think it will not be needed, in the event the receipt is requested by the Claims Administrator.

8. Pay at the pharmacy with your Visa Humana*Access* Card.

   Here are the steps to take when paying at the pharmacy:

   - When you pick up your prescription, present your primary insurance card so your pharmacist can identify your copayment amount and bill your insurer.
   - Ask your pharmacist to follow the instructions on the Humana*Access* card to submit a second claim to Humana, which takes only a few minutes.
   - Then swipe your Humana*Access* card through the credit card machine, to make the payment.
   - Select "credit" – not "debit" – for your transaction.
   - Sign and save the receipt.

   To find a complete list of participating pharmacies, please visit kyhealthplan.com.

9. 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 HRA. If no claims are submitted prior to the date you terminate coverage in the *Plan*, or claims are submitted but they are not sufficient to cover the unsubstantiated expense amount, then the amount may be withheld from your pay (as specified in the Cardholder Agreement). Lastly, the *employer* may treat the unreimbursed amount as a bad business debt, which could have income tax implications for you.

10. 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.

MAXIMUM AMOUNT OF REIMBURSEMENT

The maximum reimbursement amount that you can receive is equal to your Health Reimbursement Account balance at the time the request for reimbursement is processed.

DENIED CLAIMS

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

UNCLAIMED HEALTH CARE REIMBURSEMENTS

Any funds that you are not entitled to carry over will be forfeited and returned to the *employer*.

The Carry Over amount will be allocated to your Health Reimbursement Account by Humana after the HRA Run Out Period. Please view the Reimbursement section of this *Summary Plan Description* to determine the Health Reimbursement Account limits for your Health Reimbursement Account.

COBRA CONTINUATION COVERAGE

A federal law called "COBRA" requires most employers sponsoring group health plans to offer covered *employees* and certain covered family members the opportunity for a temporary extension of health care coverage (called "Continuation Coverage") in certain instances where coverage under the group health plan would otherwise end. These rules apply to the *Plan* (including the HRA) unless the *Employer* is a small *employer* as defined under applicable law. The *Plan Administrator* will tell you whether the *Plan* is subject to these rules. Below is a description of your rights and responsibilities under COBRA.

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

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

When Coverage May Be Continued Under COBRA:
If you are a Participant or an Eligible Dependent under the HRA, then you may continue your coverage under the HRA if you elect COBRA continuation coverage.

Type of Coverage
If you choose continuation coverage, you are entitled to the level of coverage under the HRA in effect for you immediately preceding the *qualifying event*. At the beginning of each *plan year* that COBRA is in effect, you will be entitled to an increase in your Health Reimbursement Account Balance equal to the sum of the HRA dollars allocated to similarly situated active *participants* (subject to any restrictions applicable to similarly situated active *participants*) so long as you continue to pay the applicable premium.

Cost
For the period of continuation coverage, the cost of such coverage will not exceed 102% of the "applicable premium", as determined by the *Plan Administrator*, or 150% of the "applicable premium" during any disability extension to which you may be entitled, as determined by the Social Security Administration. The *Plan Administrator* will notify you of the applicable premium. The notice you receive will describe the premium payment requirements under the *Plan* (e.g., who you pay the premium to, etc.).

APPENDIX I

CLAIMS REVIEW PROCEDURE CHART

The *Effective Date* of this Appendix I is January 1, 2008. 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:

- The reason(s) for the denial and the *Plan* provisions on which the denial is based;
- 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;
- A description of the *Plan*'s appeal procedures and the time limits applicable to such procedures; and
- 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.

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.

MISCELLANEOUS RIGHTS UNDER THE HRA

Continue Group Health Plan Coverage

You may continue health care coverage for yourself, *Spouse* or Dependent children if there is a loss of coverage under the *Plan* as a result of a *qualifying event*. You or your eligible Dependents will have to pay for such coverage. You should review the relevant sections of the HRA Summary for more information concerning your COBRA continuation coverage rights.

APPENDIX II

QUALIFYING EVENT CHART

Event	Commonwealth Choice Health Reimbursement Account (Waiver Only)
Change in Employee's Legal Marital Status	
Marriage (Gain Spouse)	Employee may terminate election and redirect the state contribution to health insurance.
Divorce, legal separation, annulment (Lose Spouse)	Employee may terminate election and redirect the state contribution to health insurance <u>if event causes loss of coverage under spouse's plan</u> (10)
Spouse's death	Employee may terminate election and redirect the state contribution to health insurance <u>if event causes loss of coverage under spouse's plan (10)</u>
Change in Number of Employee's Dependents	
Number of employee's eligible dependents decreases (e.g., by death or because child comes ineligible)	Does not apply No change allowed
Change in Employee's Employment Status	
Employee terminates employment	Cease employer contributions; COBRA rules may apply
Employee is rehired less than 30-days after termination of employment.	Employee may reinstate prior election unless another event has occurred that allows a change (9)
Employee is rehired 30 days or more after termination of employment	Employee may make election to same extent permitted as new employee
Employee commences official leave without pay	Employer contributions cease in accordance with Plan rules; COBRA rules may apply
Employee returns from official leave without pay	Reinstate prior election unless another event has occurred that allows a change (9)
Employee begins unpaid FMLA (4)	Elections continue for up to 12 weeks or until employment terminates or until employee begins official leave without pay, whichever comes first.
Employee returns from unpaid FMLA	Continue contributions
Employee begins unpaid Military Leave	Cease contributions

Event	Commonwealth Choice Health Reimbursement Account (Waiver Only)
Employee returns from unpaid Military Leave * Employees returning from Military Leave are eligible for coverage immediately upon return or may delay the effective date until military coverage ends.	Employee may reinstate contributions or reinstate prior election unless another event has occurred that allows a change (9)
Employee commences paid leave (assuming event does not affect eligibility for coverage)	Does not apply No change allowed
Employee returns from paid leave	Does not apply No change allowed
Employee changes worksite	Does not apply No change allowed
Other change in employee's employment status (e.g., switch from salaried to hourly status) that causes employee to cease eligibility under plan	Employer contributions cease; COBRA rules may apply
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	Employee may make elections as if a new employee, unless there was less than a 30- day break in eligibility
Change in Spouse or Dependent Employment Status (Dependent must continue to meet all eligibility requirements.)	
Spouse or dependent terminates employment (or other change in employment status resulting in a loss of eligibility under the spouse or dependent's plan)	Employee may stop election and redirect the state contribution to health insurance if event causes loss of coverage under spouse's plan (10)
Spouse or dependent commences employment (or other change in employment status triggering eligibility under the spouse or dependent's plan)	Does not apply No change allowed
Spouse or dependent is out of work due to strike or lockout	Employee may stop election and redirect the state contribution to health insurance if event causes loss of coverage under spouse's plan (10)
Spouse or dependent returns to work following cessation of strike or lockout	Does not apply No change allowed

Event	Commonwealth Choice Health Reimbursement Account (Waiver Only)
Spouse or dependent commences unpaid leave (if the event adversely affects eligibility for coverage under the spouse or dependent's plan)	Employee may terminate election and redirect the state contribution to health insurance if event causes loss of coverage under spouse's plan (10)
Spouse or dependent returns from unpaid leave	Does not apply No change allowed
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)	Employee may terminate election and redirect the state contribution to health insurance if event causes loss of coverage under spouse's plan (10)
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)	Does not apply No change allowed
Change in Dependent Eligibility	
Dependent ceases to satisfy plan eligibility requirements on account of age, marriage or any similar circumstance (support and maintenance)	Does not apply No change allowed
Unmarried dependent re-establishes plan eligibility requirement under applicable plan	Does not apply No change allowed
Change in Residence	
Employee or spouse changes primary (6) residence and becomes ineligible for current benefit election	Does not apply No change allowed
Other Events	
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	Employee may terminate election and redirect the state contribution to health insurance (10)
Judgment, decree, or administrative order relating to health coverage for child	Employee may terminate employer contribution
Employee, spouse, or dependent enrolled in employer's health plan becomes entitled to Medicare (Part A or Part B) or Medicaid	Does not apply No change allowed
Employee, spouse, or dependent loses entitlement to Medicare (Part A or Part B), Medicaid, KCHIP, any governmental group health insurance coverage	Employee may terminate election and redirect the state contribution to health insurance (10)

Event	Commonwealth Choice Health Reimbursement Account (Waiver Only)
Cost or Coverage Changes (8)	
Change in Cost	
Benefit option has significant increase or decrease in cost	Does not apply No change allowed
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 Enrolment and before January 1:* Employee may make corresponding changes and redirection of state contributions is allowed (10) *After 12/31:* Employee may make corresponding changes (10)
Employee makes elections during an open enrollment period of another employer that differs from the open enrollment period of the employer (7)	*After Open Enrolment and before January 1:* Employee may make corresponding changes and redirection of state contributions is allowed (10) *After 12/31:* Employee may make corresponding changes (10)
Retiree makes elections during an open enrollment period of a state sponsored retirement system that differs from the open enrollment period of the employer	Does not apply No change allowed
Individual changes election for any other event that is permitted under regulation (and terms of the employer plan)	Does not apply No change allowed

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 a "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, Select or Premier).

Efective Dates

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

Health Insurance

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 of the 1st month from the employee's signature date.
3. Different Open Enrollment = 1st day of the 1st month (match effective date of other employer's plan).

B. Events decreasing coverage

1. Termination of employment = Last day of the month following the month in which employment ends.
2. Death = Date of death.
    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.
3. Divorce, loss of dependent status = End of the month of loss of eligibility.
4. Gaining other health insurance coverage (Medicare/Medicaid/Tricare/etc.) = End of the month from the employee's signature date.
5. Different Open Enrollment = Last day of the month (match other employer's plan).

Healthcare Flexible Spending Account (HC FSA)

A. Events starting or increasing HC FSA contributions

1. Birth, adoption, placement for adoption = 1st day of the 1st month from the employee's signature date.
2. Marriage, loss of other coverage, court or administrative orders for dependent(s) or foster child(ren), expiration of COBRA = 1st day of 1st month from the employee signature date.
3. Different open enrollment = 1st day of the 1st month (match effective date of other employer's plan).
4. Return from Leave Without Pay = 1st day of the 1st month from the employee's signature date.
5. Return from Military Leave = Date of return to work.

B. Events stopping or decreasing HC FSA contributions

1. Termination of employment = Date of termination of employment.
2. Death = Date of death.
3. Divorce, loss of dependent status = End of the month of loss of eligibility.
4. Gaining other health insurance coverage (Medicare/Medicaid/Tricare/etc.) = End of the month from the employee's signature date.
5. Different open enrollment = Last day of the month (match other employer's plan).
6. Begins Leave without Pay or Military Leave = Last date of work.

Dependent Care Flexible Spending Account (DC FSA)

A. Events starting or increasing DC FSA contributions

1. Dependent is newly eligible to begin attending day care = 1st day of 1st month from the employee's signature date.
2. Change in dependent's eligibility status = 1st day of 1st month from the employee's signature date.

B. Events stopping or decreasing DC FSA contributions

1. Termination of employment = Date of termination of employment.
2. Dependent no longer attends day care = End of the month from the employee's signature date.
3. Change in dependent's eligibility status = End of the month from the employee's signature date.
4. Death = Date of death.

Health Reimbursement Account (HRA)

A. Events allowing enrollment in a Health Plan

1. Birth, Adoption, placement for adoption = Date of the event.
2. Marriage, loss of other coverage, court or administrative orders for dependent(s), expiration of COBRA = 1st day of the 1st month from the employee signature date.
3. Different open enrollment = 1st day of the 1st month (match effective date of other employer's plan).
4. Returning from Military Leave = Date of return to work or day after TRICARE ends (employee's option).

B. Events allowing contributions to cease (for reasons other than enrolling in the plan).

1. Termination of employment = Date of termination of employment.
2. Death = Date of death.
3. Different open enrollment = Last day of the month (match other employer's plan).
4. Start Military Leave = Date of the event.

APPENDIX II (continued)

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 are 60-days. Qualifying Events dealing with loss of other group coverage or gaining other group coverage may be signed by the employee prior to the Qualifying Event date. In any case, a requested change due to a Qualifying Event will not be effective prior to the event taking place.

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.

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

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
- Gynecologist's 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

Hearing Care:

Allowable Expenses

- Hearing aids
- Batteries for operation of hearing aids

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

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
- 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 for insurance coverage including long-term care
- Capital expenditures (i.e. construction costs, elevators, swimming pool, or hot tub)

Over the Counter (OTC) Medications:

Allowable Expenses

Antiseptics

- Antiseptic wash or ointment for cuts of scrapes
- Benzocaine swabs
- Boric acid powder
- First aid wipes
- Hydrogen peroxide
- Iodine tincture
- Rubbing alcohol
- Sublimed sulfur powder

Asthma Medications

- Bronchodilator / Expectorant tablets
- Bronchial asthma inhalers

Cold, Flu, and Allergy Medications

- Allergy medications
- Cold relief syrup
- Cold relief tablets
- Cough Drops
- Cough syrup
- Flu relief tablets or liquid
- Medicated chest rub
- Nasal decongestant inhaler
- Nasal decongestant spray or drops
- Nasal strips to improve congestion
- Saline nose drops
- Sinus and allergy homeopathic nasal spray
- Sinus medications
- Vapor patch cough suppressant

APPENDIX III (continued)

Diabetes

- Diabetic lancets
- Diabetic supplies
- Diabetic test strips
- Glucose meter

Ear / Eye Care

- Ear water-drying aid
- Ear wax removal drops
- Eye drops
- Homeopathic earache tablets
- Contact lens solutions
- Reading glasses

Health Aids

- Adhesive or elastic bandages
- Antifungal treatments
- Condoms
- Denture adhesives
- Diuretics and water pills
- Feminine antifungal treatments
- Hemorrhoid relief
- Incontinence supplies
- Lice control
- Medicated bandages
- Motion sickness tablets
- Respiratory stimulant ammonia
- Sleeping aids

Pain Relief

- Arthritis pain reliever
- Cold sore remedy
- Itch relief
- Orajel ®
- Pain relievers, aspirin and non-aspirin
- Throat pain medications

Personal Test Kits

- Blood pressure meter
- Cholesterol tests
- Colorectal cancer screening tests
- Home drug tests
- Ovulation indicators
- Pregnancy tests
- Thermometers

Skin Care

- Acne medications
- Anti-itch lotion
- Bunion and blister treatments
- Cold sore and fever blister medications
- Corn and callus removal medications
- Diaper rash ointment
- Eczema cream
- Medicated bath products
- Wart removal medications

Stomach Care

- Acid reducers
- Antacid gum
- Antacid liquid
- Antacid tablets
- Anti-diarrhea medications
- Gas prevention food enzyme dietary supplement
- Gas relief drops for infants and children
- Ipecac syrup
- Laxatives
- Pinworm treatment
- Prilosec®
- Upset stomach medications

Specifically Disallowed

- Aromatherapy
- Baby bottles and cups
- Baby oil
- Baby wipes
- Breast enhancement system
- Cosmetics
- Dental floss
- Deodorants
- Facial care
- Feminine care
- Fragrances
- Hair regrowth
- Low carbohydrate foods
- Low calorie foods
- Petroleum jelly
- Shampoo and conditioner
- Skin care products not previously mentioned
- Spa salts
- Tooth brushes

Physicals:

Allowable Expenses

- Routine and preventive physicals
- School and work physicals

Prescription Drugs:

Allowable Expenses

- Prescription drugs or insulin
- Birth control drugs (prescribed)

Specifically Disallowed

- Vitamins or experimental drugs

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*

Treatments and Therapies:

Allowable Expenses

- X-ray treatments
- Treatment for alcoholism or drug dependency
- Acupuncture to treat a medical condition
- Vaccinations
- Physical therapy (as a medical treatment)
- Speech therapy
- Smoking cessation programs

Specifically Disallowed

- Physical treatments unrelated to specific health problem (e.g., massage 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

APPENDIX III (continued)

Dual Use – requires letter from your doctor:

Allowable Expenses

- Foot spa
- Gloves and masks
- Herbs
- Leg or arm braces
- Massagers
- Minerals
- Special supplements
- Special teeth cleaning system
- Sun tanning products
- Vitamins
- Weight loss maintenance programs

APPENDIX IV

DEFINITIONS

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.

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

Plan **-** means this 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.

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.

Redirection – means the ability to stop the employer contribution from being deposited into an HRA in order to receive the employer established contribution toward health insurance coverage.

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.

APPENDIX V

NOTICE OF PRIVACY PRACTICES (SUMMARY)

THIS NOTICE DESRCIBES HOW YOUR PROTECTED HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

This Notice describes the obligations of the Department for Employee Insurance (DEI) and your legal rights regarding your Protected Health Information (PHI) under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Among other things, this Notice describes how your PHI may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law. This is a summary of DEI's Notice of Privacy Practices. For a complete Notice, please go to our web site at www.kehp.ky.gov or call our Member Services Branch at 888-581-8834.

The Kentucky Employees Health Plan (KEHP) is a self-funded governmental plan and, therefore, we are required to provide this Notice of Privacy Practice to you pursuant to HIPAA. DEI is the plan sponsor.

The HIPAA Privacy Rule protects only PHI. Generally, PHI is individually identifiable health information, including demographics information, collected from you or created or received by a health care provider, health care clearing house, or your employer on behalf of a group health plan that relates to: 1) your past, present, or future physical or mental health or condition; 2) the provisions or health care to you; or 3) past, present, or future payment for provisions of health care to you. DEI does not maintain information regarding your specific medical condition but does maintain PHI related to demographic information and other information that is necessary for determining eligibility and enrollment in the KEHP. If you have any questions about this Notice or about our Privacy Practices, please visit http://personnel.ky.gov/benefits/dei/hipaa.htm or contact Department for Employee Insurance, Attn; HIPAA Privacy Officer, 501 High Street, 2nd Floor, Frankfort, Kentucky 40601. The effective date of this Notice is January 1, 2008.

DEI Responsibilities

We are required by law to: 1) maintain the privacy of your PHI; 2) provide you with certain rights with respect to your PHI; 3) provide you with a copy of this Notice of our legal duties and privacy practices with respect to your PHI; and 4) follow the terms of the Notice that is currently in effect. We reserve the right to change the terms of Notice and to make new provisions regarding your PHI that we maintain, or as required by law.

APPENDIX V (continued)

How DEI May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your PHI under certain circumstance without your permission. The following categories represent the different ways that we may use or disclose your protected health information: 1) For Treatment; 2) For Payment; 3) For Health Care Operations; 4) To Business Associates; 5) As Required by.