COMMONWEALTH OF KENTUCKY

KENTUCKY EMPLOYEES' HEALTH PLAN (KEHP)

HEALTH REIMBURSEMENT ACCOUNT (WAIVERS ONLY)

SUMMARY PLAN DESCRIPTION

The Plan Sponsor has established and continues to maintain this Commonwealth of Kentucky (KEHP) 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, 2011

Plan Year: January 1, 2011 through December 31, 2011

Employer's Federal Tax Identification Number: 61-0600439

TABLE OF CONTENTS

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*.

GRANDFATHER CLAUSE

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

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

Commonwealth of Kentucky
Executive Director, Office of Legal Services
501 High Street
Third Floor
Frankfort, KY 40601

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

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 of Employee Insurance
501 High Street
Second Floor
Frankfort, KY 40601
502-564-0350
502-564-0351

Plan Administrator

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

Humana
Attn: Humana Spending Account Administration Team
PO Box 14167
Lexington KY 40512-4167
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. See KRS 18A.225 and 18A.227.

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, 2011. In no event will the coverage under this HRA begin before the *effective date* of this HRA.

In accordance with KRS § 18A.2254, the annual employer contribution for the Stand-Alone Health Reimbursement Account (HRA) is offered exclusively to Participants that decline (i.e. waive) coverage and is $175.00 per month not to exceed $2,100.00 per year. Employees, who are hired with an effective date of January 1, will receive $175.00 for each month in which Participant is eligible for a health insurance benefit but declines (i.e. waive) coverage under the plan.

If a Medicare eligible employee is re-employed by any agency of the Commonwealth in a position working at least 100 hours per month (or otherwise eligible for benefits pursuant to KRS 18A.225), he or she will be eligible to re-enroll (or to remain enrolled) in the Kentucky Employees' Health Plan. While a Medicare eligible retiree is actively employed by the Commonwealth and eligible to participate in the KEHP (including the HRA Waiver), federal law provides that he or she is **not eligible** to receive coverage from any Kentucky retirement system (including the Kentucky Retirement System, Judicial/Legislative Retirement, and Kentucky Teachers' Retirement System, etc.) that supplements the employee's Medicare coverage. According to federal Medicare laws, a health plan (including the HRA Waiver) must pay primary to Medicare. Therefore, any health coverage the employee receives from a Kentucky-sponsored program (KEHP) must pay for Medicare-covered expenses, up to the limit of his or her coverage under the Kentucky program, before applying to Medicare for payment.

If an employee is currently receiving Medicare supplemental coverage from one of the Kentucky retirement system(s), the employee should drop this supplemental coverage while he or she is actively employed and eligible to participate in the KEHP.

Because the KEHP's "waiver" Health Reimbursement Account is "general purpose", you also may not be eligible to receive the HRA contribution if you or your spouse participates in a Health Savings Account (HSA).

ELECTION CHANGES

You can change your election under the Health Reimbursement Account (HRA) in the following situations:

(i). For any reason during the Annual Open Enrollment Period. The election change will be effective the first day of the Plan Year following the end of the Annual Open Enrollment Period.

(ii) Following a Qualifying Event. You may change your Health Reimbursement Account (HRA) election during the Plan Year only if you experience an applicable Qualifying Event.

Qualifying events are determined by your Employer and 'based on' 26 C.F.R. § 1.125-4 and Proposed Treasury Reg 1.125-2(a). Qualifying Events must be elected and signed by the employee 35 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.

LEAVE OF ABSENCE

Please see your Employer or Insurance Coordinator to determine what, if any, specific changes you can make during a leave of absence. If your Health Reimbursement Account coverage ceases during an FMLA leave, you may, upon returning from FMLA leave, elect to be reinstated in the Health Reimbursement Account at either

(i) The same coverage level in effect before the FMLA leave; or

(ii) At the same coverage level that is reduced pro-rata for the period of FMLA leave. Under either scenario, expenses incurred during the period that your Health Reimbursement Account coverage was not in effect are not eligible for reimbursement under this Health Reimbursement Account.

ELIGIBLE DEPENDENTS

Dependent means the following:

1. Spouse -a person of the opposite sex to whom you are legally married.

2. Common Law Spouse - a person of the opposite sex with whom you have established a Common Law union **in a state which recognizes Common Law marriage** (Kentucky does not recognize Common Law Marriage).

3. Child Age 0 to 18 - in the case of a child who has not yet attained his/her 19th birthday, "child" means an individual who is:

    a. A son, daughter, stepson, or stepdaughter of the *employee*/retiree, or

    b. An eligible foster child of the *employee*/retiree (eligible foster child means an individual who is placed with the *employee*/retiree by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction), or

    c. An adopted child of the *employee*/retiree (a legally adopted individual of the *employee*/retiree, or an individual who is lawfully placed with the *employee*/retiree for legal adoption by the *employee*/retiree, shall be treated as a child), or

    d. A grandchild for whom the *employee*/retiree has been awarded guardianship or custody by a court of competent jurisdiction.

4. Child Age 19 to 25 - in the case of a child who has attained his/her 19th birthday but who has not yet attained his/her 26th birthday, "child" means an individual who is:

    a. A son, daughter, stepson, stepdaughter, eligible foster child, adopted child or a grandchild of the employee/retiree – as described above; and

    b. Is NOT eligible to enroll in an employer-sponsored health plan offered by the child's full-time employer.

5. Disabled Dependent - A dependent child who is totally and permanently disabled may be covered on your KEHP benefit plan beyond the end of the month in which he/she turns 26, provided the disability (a) started before his/her 26th birthday and (b) is medically-certified by a physician. A disabled child who was not covered on this Plan prior to his/her 26th birthday may not be enrolled in KEHP unless he/she sustains a specific qualifying event.

PLEASE NOTE:

- A Cross Reference Payment Option is a payment option involving two employees/retirees who are a legally married couple and enroll themselves and at least one child as a dependent in a KEHP family plan.

- A dependent must meet KEHP's eligibility rules before an employee/plan holder may add the dependent to the Plan. Upon reaching age of termination the dependent child will become ineligible and be terminated as a dependent at the end of the month in which the birthday occurs.

- Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. This includes adding a dependent to the Plan who does not meet the KEHP eligibility rules.

- The KEHP requires documentation to verify a dependent's eligibility before coverage will be provided under the Plan. Examples of such documentation include but are not limited to marriage certificate, birth certificate, court documents and/or guardianship papers.

The health care reform law (Patient Protection and Affordable Care Act) generally requires group health plans that offer dependent coverage to continue making such coverage available for an adult child until age 26 for plan years beginning on January 1, 2011.

The IRS, DOL, and HHS have jointly issued interim final regulations implementing the coverage requirement for adult children. Under these regulations, children who become (or are required to become) eligible to enroll as a result of this requirement must be given written notice of their enrollment right not later than the first day of the plan year. They must be given at least 30 days to enroll, regardless of whether the plan otherwise offers an open enrollment period.

This notice of the eligibility changes was provided via U.S. Mail to all KEHP members in their 2011 Open Enrollment materials. The KEHP 30 day special enrollment period for individuals (whose KEHP coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26) to request enrollment in the KEHP for such children began on October 1, 2010 and ended on October 31, 2010.

In general, a dependent under the KEHP for purposes of accident or health coverage is a dependent as defined as in Code § 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof, (2) any child (as defined in Code § 152(f)(1)) of the Participant who as of the end of the taxable year has not attained age 27, and (3) any child of the Participant to whom IRS Rev. Proc. 2008-48 applies (regarding certain children of divorced or separated parents who receive more than half of their support for the calendar year from one or both parents and are in the custody of one or both parents for more than half of the calendar year). Because this plan is "grandfathered" for plan year 2011, this plan is not required to extend coverage to children who are eligible for coverage under another employer's group health plan (*e.g.,* eligible under the plan of the child's own employer). This plan has interpreted this to mean the child full-time employer. A "grandfathered" plan cannot deny coverage if a child is eligible for coverage under another *parent's* group health plan, however.

A "child" is an individual who is the employee's son, daughter, stepson, or stepdaughter, and includes both a legally adopted individual of the employee and an individual lawfully placed with the employee for legal adoption by the employee. The term "child" also includes an eligible foster child, defined as a child placed with the employee by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

The definition change the age limit, residency, support, and other tests that would otherwise have to be met in order for an individual to qualify as a tax dependent under the Code do not apply to such an employee's child for purposes of the tax-favored treatment of health coverage that is available under Code §§ 105(b) and 106.

The status as a "qualifying child" or "qualifying relative" under Section 152 will continue to be relevant when determining the tax treatment of health coverage for individuals who are not an employee's spouse or child.

Individuals under a civil union or domestic partnership are not eligible for coverage under this plan. Dependent status between a Participant and dependent or other individual must not violate federal, state or local law.

REDIRECTION OF EMPLOYER CONTRIBUTION

A *Participant* may be eligible to redirect the employer contribution. Please contact your Insurance Coordinator for details.

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.

EMPLOYEE EFFECTIVE DATE OF COVERAGE

You must enroll on forms acceptable to the Plan Sponsor

1. If your completed enrollment forms are signed by you within thirty five (35) days after *your* hire date, *your* coverage is effective on the 1st day of the 2nd month following the month of hire. Your coverage may be effective at a later date as determined by the Plan Sponsor.

2. If your completed enrollment forms are signed by *you* more than thirty five (35) days after *your* hire date , *you* are a *late applicant* and you will not be eligible for coverage under this Plan until the next annual open enrollment period or until you experience a permitted *qualifying event*. *Your* coverage is effective as determined by the Plan Sponsor.

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.

AVAILABLE FUNDS

Each *Plan Year*, the *Employer* allocates a specified notional 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 continue to waive health insurance coverage and you remain eligible to receive the funds. You must re-enroll each year to receive coverage.

Under no circumstances can an employee receive more than $175.00 per month and $2,100.00 per plan year.

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
Prescriptions
Vision
Durable Medical Equipment
Insulin
Over-the-Counter Code Section 213(d) products & devices
Preventive Health Care
Prescribed Over the Counter Medications
Dental

The list above is a general categorical list for eligible expenses. To obtain a detailed sample list, visit Humana's website at www.myhumana.com or call 877-KYSPIRIT (877-597-7474) to obtain a list of eligible expenses. This list is subject to change.

NOTE: Effective January 1, 2011, HRA funds may no longer be used to purchase over-the-counter medications (OTCs). You may be able to obtain reimbursement with a receipt and prescription.

*My*Humana is personal, password-protected access on Humana's home page that provides information and tools to help covered persons make informed decisions. Log in to MyHumana, at www.humana.com, anytime to check the status of your HRA account. You can also find financial tools to help with budgeting for health care and more.

Please follow the directions below when accessing Humana's website:

1. Go to Humana's website (www.humana.com) and log-in as a Registered Member;
2. Click on "My Claims & Spending", "Spending Accounts" (on your welcome page);
3. Locate the "Related Information" section in the middle of the webpage;
4. Click on "FSA/PCA Eligible Expenses";
5. Save, print or download a PDF format of the "FSA/PCA Eligible Expenses" list.

"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;
- Over-the-counter drugs or medicines that have not been prescribed;
- 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 a Humana*Access* card (see "Electronic Payment Card" below for more information) to pay the expense. In order to be eligible for the Humana*Access* 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 Humana*Access* 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.

HRA claim is deemed filed when it is received by Humana. If your claim for reimbursement is approved, you will be provided reimbursement as soon as reasonably possible following the determination.

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 for active *employees* is 90 days after the end of the *plan year*.

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 your health plan) you will be required to refund the overpayment or erroneous reimbursement to the HRA.

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.

TRADITIONAL PAPER CLAIMS

When you incur an Eligible Medical Expense, you file a claim with Humana by completing and mailing or faxing a Request for Reimbursement Form. Forms can be mailed to PO Box 14167, Lexington, KY 40512-4167 or faxed to 1-800-905-1851. You may obtain a Request for Reimbursement Form from Humana or print a copy from the KEHP website at www.kehp.ky.gov. 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) If the expense is for a prescribed over- the- counter drug, the written statement must indicate the name of the drug;

(iii) The date the expense was incurred; and

(iv) The amount of the expense.

Humana 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 Humana*Access* 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 Humana*Access* card, you must agree to abide by the terms and conditions of the Program as set forth herein and in the Humana*Access* 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 Open Enrollment 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 if you fail to provide the correct documentation to Humana, when necessary to substantiate claims. If Humana does not receive substantiation (verification) from you within thirty (30) days after you swipe the Humana*Access* card, then Humana will request this substantiation from you. If substantiation is not received within 30 more days (for a total of 60 days from the initial Humana*Access* card swipe), then claims processing will be suspended. This suspension of claims will include the use of the Humana*Access* card as well as reimbursements for traditional paper claims.

   The card will be turned off when you terminate employment or when coverage under the *Plan* ends.

3. 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 dependents).You also certify 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 the Humana*Access* card use privileges.

4. Use of the Humana*Access* card for HRA expenses is limited to merchants who are health care providers (doctors, pharmacies, etc.). As set forth in the Cardholder Agreement, you may be able to use the Humana*Access* card at a regular retail store – e.g., a supermarket, grocery store, or discount store with a pharmacy – if the facility has installed the Inventory Information Approval System (IIAS). If the IIAS system is not installed at a regular retail store, you will need to submit HRA expenses for reimbursement using a traditional paper claim..

5. 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 Humana*Access* 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 Humana*Access* card. Every time you swipe the Humana*Access* 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 Humana*Access* 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 Humana*Access* 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, 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 Humana*Access* 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/coinsurance 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.

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 Humana*Access* card will be turned off and an amount equal to the unsubstantiated expense may be offset against future eligible claims under the HRA. The Plan further reserves the right to withhold the amount of any unsubstantiated expenses from your paycheck and to take any additional steps deemed necessary to properly account for any unsubstantiated expenses.

10. You can use either the Humana*Access* 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 Humana*Access* card, you may also submit claims under the Traditional Paper Claims approach discussed above. Claims for which the Humana*Access* card has been used cannot be submitted as Traditional Paper Claims.

11. This plan reserves the right to initiate the following correction procedures to recoup money from participants for claims that are improperly paid from the health HRA (i.e., a claim that qualifies for after-the-fact-substantiation for which proper substantiation is not subsequently provided).

- Deny Access to the Humana*Access* card. To ensure that no further violations occur, the Humana*Access* card must be deactivated until the amount of the improper payment is recovered. In the meantime, the participant must request reimbursements through other methods (e.g., by submitting traditional paper claims).

- Require Repayment. The employer may "demand" that the participant repay the improper payment. A letter to the participant will be sent identifying the amount, the reasons for requiring repayment, and the timeframe in which the repayment must be made.

- Withhold From Pay. If the demand for repayment is unsuccessful, then an amount equal to the improper payment must be withheld from the participant's pay or other compensation, to the full extent permitted under applicable law.

- Offset. If the improper payment is still outstanding and amounts are not available to be withheld, then the employer is to apply a substitution or offset approach against subsequent valid claims, up to the amount of the improper payment.

- Treat Payment as Other Business Indebtedness. If the above correction efforts prove unsuccessful, then the employee remains indebted to the employer for the amount of the improper payment. In that event, and consistent with its business practices, the employer may treat the payment as it would treat any other business indebtedness.

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.

PRIVACY OF PROTECTED HEALTH INFORMATION

This *Plan* is required by law to maintain the privacy of *your protected health information* in all forms including written, oral and electronically maintained, stored and transmitted information and to provide individuals with notice of this *Plan's* legal duties and privacy practices with respect to *protected health information*.

This *Plan* has policies and procedures specifically designed to protect *your* health information when it is in electronic format. This includes administrative, physical and technical safeguards to ensure that *your* health information cannot be inappropriately accessed while it is stored and transmitted to Humana and others that support this *Plan*.

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

A *covered person* will be deemed to have consented to use of *protected health information* about him or her for the sole purpose of health care operations by virtue of enrollment in this *Plan*. This *Plan* must obtain authorization from a *covered person* to use *protected health information* for any other purpose.

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

Disclosure of *protected health information* is improper if it is not allowed by law or if it is made for any purpose other than *Plan* operation or benefits delivery without authorization. Disclosure for *Plan* purposes to persons authorized to receive *protected health information* may be proper, so long as the disclosure is allowed by law and appropriate under the circumstances. Improper disclosure includes disclosure to the *employer* for employment purposes, *employee* representatives, consultants, attorneys, relatives, etc. who have not executed appropriate agreements effective to authorize such disclosure.

Humana will afford access to *protected health information* in its possession only as necessary to discharge its obligations as a service *provider*, within the restrictions noted above. Information received by Humana is information received on behalf of this *Plan*.

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

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

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

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

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

Please see the Kentucky Employees' Health Plan Notice of Privacy Practices and HIPAA Privacy and Security Policies for additional information.

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, 2011. 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 Humana. If your claim is denied, you will receive written notice from Humana 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 Humana, Humana 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 Humana 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 Humana, 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 Humana 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 Humana. 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 Humana.

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 Humana.

Step 6: If you still disagree with Humana's decision, file a 2nd Level Appeal with the *Plan Administrator*. If you still do not agree with Humana'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 Humana. 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.
- To the extent these claims review and appeals procedures are carried out in compliance with applicable federal rules and regulations, you cannot proceed to external review or file suit in Federal Court until you have exhausted these appeals procedures.

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.

Medicare and Medicare Secondary Payer

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

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

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

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

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

You have the option to reject plan coverage offered by *your employer*, as does any eligible *employee*. If *you* reject coverage under *your employer's Plan*, coverage is terminated and *your employer* is not permitted to offer *you* coverage that supplements *Medicare covered services*. This includes any Medicare Supplement coverage that may be available to you as a result of your retirement through a Kentucky Retirement System.

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

If you are Medicare eligible and maintain a KEHP health plan or an HRA, please be advised that your health plan and HRA are primary (i.e. pay before) Medicare for Medicare covered expenses.

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

APPENDIX II

This Plan has adopted qualifying events (i.e. election changes) "based on" 26 C.F.R § 1-125-4 and Prop. Treas. Reg. § 1.125-2(a)(1). Please contact your employer or insurance coordinator for additional information concerning this Plan's qualifying events.

Effective Dates

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

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.

All Qualifying Events must be signed by the employee 35 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.

Visit Humana's website at www.myhumana.com or call 877-KYSPIRIT (877-597-7474)for additional information regarding the list of eligible expenses outlined.

*My*Humana is personal, password-protected access on Humana's home page that provides information and tools to help covered persons make informed decisions. Log in to MyHumana, at www.humana.com, anytime to check the status of your HRA account. You can also find financial tools to help with budgeting for health care and more.

Please follow the directions below when accessing Humana's website:

1. Go to Humana's website (www.humana.com) and log-in as a Registered Member;
2. Click on "My Claims & Spending", "Spending Accounts" (on your welcome page);
3. Locate the "Related Information" section in the middle of the webpage;
4. Click on "FSA/PCA Eligible Expenses";
5. Save, print or download a PDF format of the "FSA/PCA Eligible Expenses" list.

In addition 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:

Effective January 1, 2011, FSA funds may no longer be used to purchase over-the-counter medications (OTCs). You may be able to obtain reimbursement with a receipt and a prescription.

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

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

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 a person who is employed by a Participating Agency with the Kentucky Employees' Health Plan and is eligible to apply for coverage under the Kentucky Employees' Health Plan. See KRS 18.225 and KRS 18.227.

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 Health Reimbursement Account (Waivers Only) 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 of 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/dei/hipaa.htm_or contact Department of Employee Insurance, Attn; HIPAA Privacy Officer, 501 High Street, 2nd Floor, Frankfort, Kentucky 40601. The effective date of this Notice is January 1, 2010.

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; 4) follow Breach accounting and notification requirements; and 5) 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.

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 Law;** 6) **To Avert a Serious Threat to Health or Safety;** 7) **To Plan Sponsors.**

Special Situations

In addition to the above, the following categories represent other possible ways we may use and disclose your PHI. 1) organ tissue donation, 2) military and veterans; 3) workers' compensation; 4) public health risk; 5) health oversight activities; 6) lawsuits and disputes; 7) law enforcement; 8) coroners, medical examiners and intelligence activities; 9) inmates; and 10) research.

Required Disclosures

DEI is required to disclose your PHI to you (as a participant) and for Government audits.

Other Disclosures

Other disclosures may be made to your personal representatives, spouses and other family members and with written authorization. DEI's HIPAA Forms may be located at http://personnel.ky.gov/dei/hipaa.htm.

Participant Rights

A participant has the following rights with respect to their PHI: 1) right to inspect and copy; 2) right to amend; 3) right to an accounting of disclosures; 4) right to request restrictions; 5) right to request confidential communications; and 6) right to a paper copy of this Notice.

Breach defined

The Breach Regulations provide a specific definition of "breach" for purposes of the notice obligations. Compliance with the Breach Regulations hinges on understanding this definition and being able to identify "breaches." A "breach" for purposes of the Breach Regulations and the corresponding notice obligation occurs only if (i) there is an acquisition, access, use or disclosure (ii) of unsecured PHI (iii) that violates the HIPAA Privacy Rules relating to use and disclosure of PHI and (iv) that compromises the security or privacy of the unsecured PHI. The definition of "breach" has several moving parts and exceptions. Therefore not every violation of the HIPAA Privacy Rules will constitute a breach for purposes of the Breach Regulations.

Breach Notification Requirements

Following a breach of unsecured protected health information covered entities must provide notification of the breach to affected individuals, the Secretary, U.S. Department of Health & Human Services (HHS) and, in certain circumstances, to the media. In addition, business associates must notify covered entities that a breach has occurred.

1) Individual Notice

DEI shall notify affected individuals following the discovery of a breach of unsecured protected health information. DEI shall provide this individual notice in written form by first-class mail, or alternatively, by e-mail if the affected individual has agreed to receive such notices electronically. If DEI has insufficient or out-of-date contact information for 10 or more individuals, the Administrator must provide substitute individual notice by either posting the notice on the home page of its web site or by providing the notice in major print or broadcast media where the affected individuals likely reside. If the Administrator has insufficient or out-of-date contact information for fewer than 10 individuals, the Administrator may provide substitute notice by an alternative form of written, telephone, or other means.

These individual notifications must be provided without unreasonable delay and in no case later than 60 days following the discovery of a breach and must include, to the extent possible, a description of the breach, a description of the types of information that were involved in the breach, the steps affected individuals should take to protect themselves from potential harm, a brief description of what the Administrator is doing to investigate the breach, mitigate the harm, and prevent further breaches, as well as contact information for the Administrator.

2) Media Notice

When the Administrator experiences a breach affecting more than 500 residents of a State or jurisdiction are, in addition to notifying the affected individuals, it shall provide notice to prominent media outlets serving the State or jurisdiction. Like individual notice, this media notification must be provided without unreasonable delay and in no case later than 60 days following the discovery of a breach and must include the same information required for the individual notice.

3) Notice to the Secretary

In addition to notifying affected individuals and the media (where appropriate), covered entities must notify the Secretary of breaches of unsecured protected health information. Covered entities will notify the Secretary by visiting the HHS web site and filling out and electronically submitting a breach report form. If a breach affects 500 or more individuals, covered entities must notify the Secretary without unreasonable delay and in no case later than 60 days following a breach. If, however, a breach affects fewer than 500 individuals, the Administrator may notify the Secretary of such breaches on an annual basis. Reports of breaches affecting fewer than 500 individuals are due to the Secretary no later than 60 days after the end of the calendar year in which the breaches occurred.

4) **Notification by a Business Associate**

If a breach of unsecured protected health information occurs at or by a business associate, the business associate must notify the Administrator following the discovery of the breach. A business associate must provide notice to the Administrator without unreasonable delay and no later than 60 days from the discovery of the breach. To the extent possible, the business associate should provide the Administrator with the identification of each individual affected by the breach as well as any information required to be provided by the Administrator in its notification to affected individuals.

Business Associates

Effective February 17, 2010, business associates are required to fully implement the information security safeguards specified by the HIPAA Security Rule. Additionally, pursuant to the HITECH Act business associates must implement written, comprehensive information security programs that address each aspect of the HIPAA Security Rule. Business Associates shall work with the Administrator in pursuit of Breach accounting and notification requirement established by the HITECH Act.

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with DEI or with the Office of Civil Rights of the United States Department of Health and Human Services, electronic mail address: OCRMail@hhs.gov. To file a complaint with DEI please visit www.personnel.ky.gov/benefits/dei/hipaa.htm. All complaints must be in writing. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Right or with DEI.

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

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

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

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

The Newborns' and Mothers' Health Protection Act of 1996 provides that group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending *provider*, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). An attending *provider* is defined as an individual who is licensed under applicable state law to provide maternal or pediatric care and who is directly responsible for providing such care to a mother or newborn child. The definition of attending *provider* does not include a plan, *hospital*, managed care organization or other issuer. In any case, plans may not, under Federal law, require that a *provider* obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

MICHELLE'S LAW

To the extent required by the law, this plan is compliant with Michelle's Law, effective January 1, 2010. Under Michelle's Law, this plan must continue to provide coverage to a "dependent child" if the child takes a leave of absence from a postsecondary educational institution, or has a change in enrollment status, that:

1) Begins when the student is suffering from a serious injury or illness;

2) Is medically necessary (as confirmed in a written communication from the student's treating physician); and

3) Causes the child to lose student status for purposes of coverage under the plan.

A "dependent child" for purposes of Michelle's Law is a child who (1) is a dependent child of a participant or beneficiary under the terms of the plan, and (2) was enrolled in the plan on the basis of being a student at a postsecondary educational institution immediately before the medical leave of absence began.

This plan will continue the child's coverage for up to one year after the leave of absence begins or, if earlier, until coverage would have otherwise terminated under the terms of the plan

Mental Health Parity Act (MHPA) and Mental Health Parity and Addiction Equity Act of 2008

This Plan operates in compliance with Mental Health Parity Act and the Additional Equity Act of 2008 as forth in the Public Health Service Act (PHSA).

The Genetic Information Nondiscrimination Act of 2008 (GINA)

This Plan is compliant with Genetic Information Nondiscrimination Act of 2008, Pub. L. No. 110-233 (2008), § 201(2)(B), to be codified at 42 U.S.C. § 2000ff. Section 701(b) of the Civil Rights Act of 1964 is codified at 42 U.S.C. § 2000e(b).