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PERSONNEL CABINET

Kentucky Employees' Health Plan

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COMMONWEALTH OF KENTUCKY KENTUCKY EMPLOYEES' HEALTH PLAN (KEHP)

HEALTH FLEXIBLE SPENDING ACCOUNT (FSA)

SUMMARY PLAN DESCRIPTION (SPD)

Plan Year: January 1, 2024 through December 31, 2024
Effective Date: January 1, 1991
Amended and Restated: January 1, 2024

Employer's Federal Tax Identification Number: 61-0600439

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PLAN INFORMATION

INTRODUCTION

The Plan Sponsor has established and continues to maintain this Health Flexible Spending Account (the "FSA" or the "Plan") for the benefit of its Employees and their eligible dependents as provided in this document. The FSA provides reimbursement for the cost of eligible medical, dental, or other similar expenses from your pre-tax dollars.

The purpose of this SPD is to briefly describe the expenses that qualify for reimbursement, as well as provide an outline of other important information concerning the Plan, such as the rules you must satisfy before you can elect the FSA and the laws that protect your rights. This SPD describes the basic features of the FSA, how the FSA operates, and how you can get the maximum advantage from the FSA.

This SPD describes the current provisions of the Plan which are designed to comply with applicable legal requirements. The Plan is subject to federal laws, such as the Internal Revenue Code (the "Code") and other federal and state laws which may affect your rights. The provisions of the Plan are subject to revision due to a change in laws or due to pronouncements by the Internal Revenue Service (IRS) or other federal agencies. The Plan Sponsor may also amend or terminate this Plan. If the provisions of the Plan that are described in this SPD change, the Plan Administrator will notify you.

There is also a Plan Document that governs the FSA which you may review if you desire. In the event there is a conflict between this SPD and the Plan Document, the Plan Document will control.

One of the most important features of our Plan is that the benefits being offered are generally ones that you are already paying for, but normally with money that has first been subject to income and Social Security taxes. Under our Plan, these same expenses will be paid for with a portion of your pay before income or Social Security taxes are withheld. This means that you will pay less tax and have more money to spend and save.

KEHP has contracted with HealthEquity/WageWorks, Inc. ("HealthEquity") to provide certain administrative services with respect to the FSA, such as claims processing and medical expense payment and reimbursement.

Read this SPD carefully so that you understand the provisions of the Plan and the benefits you will receive. You should be fully informed before you enroll in the Plan and remain informed as a plan member. If you have any questions, you should contact KEHP at 888-581-8834 or the Spending Account Administrator, HealthEquity/WageWorks, Inc. at 877-430-5519.

Participation in the Plan 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, you may also contact the Plan Administrator.

GENERAL INFORMATION ABOUT THE PLAN

This section contains general information that you may need to know about the Plan.

1. Plan Name. Kentucky Employees' Health Plan (KEHP) Health Flexible Spending Account (FSA).

2 (a) The provisions of the Plan became effective on January 1, 1991, which is called the Effective Date of the Plan.

(b) The provisions of the amended Plan became effective on January 1, 2024.

3. The Plan's start date begins on January 1 and ends December 31, unless you are no longer eligible to participate in the Plan or your participation is otherwise terminated. This is referred to as the Plan Year.

4. Employer/Plan Sponsor Information. The Employer's name, address, and tax identification number are:

Commonwealth of Kentucky
501 High Street, Second Floor
Frankfort, KY 40601
Toll Free: 888-581-8834
Local: 502-564-6534

Tax ID#: 61-0600439

6. The Plan shall be governed under the laws of the Commonwealth of Kentucky.

7. Plan Administrator Information. The name, address and business telephone number of the Plan's Administrator is:

Commonwealth of Kentucky
Department of Employee Insurance
501 High Street, Second Floor
Frankfort, KY 40601
Toll Free: 888-581-8834
Local: 502-564-6534

The Plan Administrator keeps the records for the Plan and is responsible for the Plan. The Plan Administrator will also answer any questions you may have about the Plan. You may contact the Plan Administrator for any further information about the Plan.

8. Name and Address of the Plan Manager or "Spending Account Administrator" where claims should be submitted:

HealthEquity/WageWorks, Inc.
P.O. Box 14053
Lexington, KY 40512
Phone: 1-877-430-5519

The Spending Account Administrator manages your Health FSA including the receipt and payment of claims and the appeal of any claim denials.

9. Service of Legal Process:

The Plan Administrator is the Plan's agent for service of legal process.

10. Type of Administration:

The type of Administration is Employer Administration.

11. Eligibility Requirements.

This FSA is available to those Employees as defined in KRS 18A.225. Part-time Employees expected to work less than 30 hours per week are not eligible to participate in the FSA.

Terminated Employees, including persons who retire, shall cease to be a Participant. They shall have 90 days after the end of the calendar year of the claim service date to request reimbursement for expenses incurred up to their termination date, unless they enroll in COBRA.

12. Plan Entry Date. The Entry Date for eligible Employees shall be the same as the Employer's group Medical Plan. You will be eligible to join the Plan on the first day of the second month after you become an eligible Employee in accordance with your Employer's eligibility rules.

13. Benefits. The Plan shall reimburse eligible Employees for the cost of eligible medical expenses as defined under Code Sections 105 and 213 (without regard to the limitations contained in § 213(a)), and any accompanying regulations or other applicable Treasury guidance or information and as further described below, subject to your FSA contribution amount. (None of your FSA funds may be paid in cash or other form of distribution, other than through reimbursement of actual expenses incurred.)

Types of Eligible Medical Expenses. The following types of medical expenses qualify for reimbursement under the Plan:

- Medical Expenses
- Dental Expenses

- Vision Expenses

All medical expenses not otherwise covered by insurance (e.g., co-pays, coinsurance, deductibles, etc.) qualify for reimbursement under the Plan, except health insurance premiums or premiums paid for other types of insurance including COBRA, Medicaid, Medicare, or long-term care.

Co-insurance and co-payment charges are eligible expenses and can be reimbursed.

14. Order of Benefit Payments. KEHP sponsors Health Reimbursement Arrangements (HRAs) in addition to this Section 125 Flexible Spending Account. If you participate in both this FSA and an HRA, expenses will be paid under the FSA first.

15. Carryover amounts. A minimum of $50, up to a maximum of $610, remaining in a participant's Health FSA at the end of the Plan Year can be carried over and used in the subsequent Plan Year, to the extent not fully utilized in the current Plan Year. Unused Health FSA amounts under $50 will not carry over to the subsequent Pan Year and will be forfeited.

A Health FSA with a balance that is carried over for two consecutive Plan Years, including the Run-Out Period (described below) of the second year, will be terminated and the balance forfeited, provided there has been no new elections for the FSA during those two Plan Years. Please see the section "Unused FSA Funds" for more information.

16. Mid-Year Claims Deadline Run-Out Period (Applies to Mid-Year Termination or Cancelation)

The claims deadline is based on the claim service date instead of coverage end date. Claims must be submitted within 90 days after the end of the calendar year of the claim service date.

End-of-Plan Claims Deadline (Run-Out Period)

The claims deadline is based on the claim service date instead of the coverage end date. Claims must be submitted 90 days after the end of the calendar year of the claim service date.

17. COBRA Continuation: Qualified Employees may be eligible to elect to continue participation in the FSA when coverage would otherwise end, to the extent the Employer is subject to COBRA as set forth in the relevant Code, Employees Retirement Income Security Act of 1974 ("ERISA"), and/or Public Health Safety Act ("PHSA") statutory provisions and the applicable regulations promulgated thereunder.

18. Name and Address of Plan Continuation Coverage (COBRA) Administrator:

HealthEquity/WageWorks, Inc.
10375 N. Baldev Court Me-
quon, WI 53092
Phone: 1-877-502-6272

19. Rights Upon Termination. If a terminated Employee waives continuation coverage rights, all FSA dollars that are not applied towards eligible medical expenses incurred before the Employee's termination date are forfeited.

20. The FSA is funded with Employee funds redirected from Employee compensation, before income or Social Security taxes are applied, up to a maximum Plan Year contribution of $3,050. An Employee who elects an FSA must contribute at least $120 during the Plan Year. The Employee's elected contribution amount must be divisible by 24, or the remaining number of pay periods in the Plan Year if the Employee is a new hire.

ELIGIBILITY

ELIGIBILITY REQUIREMENTS

You are eligible to participate in this FSA once you have satisfied the eligibility requirements. Eligible Employees who become covered under this FSA are called "Participants."

Except as specified under ELIGIBILITY EXCEPTIONS below, this FSA is available to those Employees whose Employer participates in the KEHP FSA program.

ELIGIBILITY EXCEPTIONS

Notwithstanding the above, all Employees are considered eligible to participate in this Plan except:

- Part-time Employees expected to work less than 30 hours per week; and
- Employees of Employers that do not participate in KEHP's FSA program.

MEDICARE ELIGIBLE EMPLOYEES

A Medicare-eligible Employee who is re-employed by any agency of the Commonwealth and who is otherwise eligible for benefits pursuant to KRS 18A.225 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 KEHP, federal law provides that he or she is **not eligible** to receive coverage from any Kentucky retirement system (including the Kentucky Public Pensions Authority, Judicial/Legislative Retirement, and Teachers' Retirement System, etc.) that supplements the Employee's Medicare coverage. According to federal Medicare laws, a health plan 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.

ELIGIBLE DEPENDENTS

The FSA provides reimbursement for eligible expenses incurred by you, your Spouse, your child, and any other person you could claim as a dependent on your federal income tax return.

For the purposes of this Plan, the following are considered dependents:

1. Spouse – a person to whom you are legally married.

2. Common Law Spouse – a person 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 up to age 26

a. The employee's son, daughter, stepson, or stepdaughter;

b. The employee's eligible foster child. An eligible foster child means an individual who is placed with the employee by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction and includes court awards of guardianship or custody; or

c. The employee's adopted child. An adopted child means the employee's legally adopted child or a child who is lawfully placed with the employee for legal adoption.

4. A dependent child who is totally and permanently disabled may be covered on your 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 to be total and permanent. A dependent child will be considered totally and permanently disabled if, in the judgment of KEHP, the written certification adequately demonstrates that the dependent child is unable to engage in any substantial gainful activity by reason of medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months.

   A dependent child who is not already covered under the Plan at the time of his/her 26th birthday may not later be enrolled in the Plan on grounds of total and permanent disability unless and until he/she sustains a loss of other insurance coverage. In such a case, a request to enroll a dependent child in KEHP on grounds of total and permanent disability must be made no later than 35 calendar days following the loss of other insurance coverage. Once a dependent child is approved for coverage in the Plan on grounds of total and permanent disability, the employee may periodically be required to produce written or other proof of the continuing nature(s) of the child's dependency and/or disability in order to maintain the child's coverage through the Plan.

The Plan may require documentation to verify a dependent's eligibility before reimbursement 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.

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

COVERAGE INFORMATION

ELECTIONS

Before the start of each Plan Year, you will be able to elect to have some of your upcoming pay contributed to the Plan. The portion of your pay that is paid to the Plan is not subject to federal and state tax withholdings. In other words, this allows you to use pre-tax dollars to pay for certain kinds of benefits and expenses which you normally pay for with out-of-pocket, taxable dollars. However, if you receive a reimbursement for an expense under the Plan, you cannot claim an income tax credit or deduction on your state or federal income tax return.

To participate in the FSA, you must elect to participate when you become an eligible Employee or at open enrollment. You must elect the FSA electronically or using forms acceptable to the Plan Administrator. The application will require you to choose an amount (divisible by 24 or the remaining number of pay periods in the Plan Year if the Employee is a new hire, and up to the maximum contribution of $3,050) and authorize the Plan Administrator to redirect that amount from your compensation to fund your FSA.

For each new Plan Year, you may change the elections that you previously made. You may also choose not to participate in the Plan for the upcoming Plan Year. If you do not make new elections during the election period (open enrollment) before a new Plan Year begins, the Plan Administrator will consider that to mean that you have elected not to participate in the FSA for the upcoming Plan Year.

PERMITTED ELECTION CHANGES

Once you have elected an FSA, you will not be permitted to make any mid-Plan Year changes unless you experience a Qualifying Event or unless otherwise authorized by federal law or guidance. Any Participant in the FSA who experiences a Qualifying Event in accordance with Treas. Reg. § 1.125-4, KRS 18A.227(4), and Prop. Treas. Reg. § 1.125-2(a)(1) may make a mid-Plan Year election change consistent with the Qualifying Event, the terms of this Plan, and this SPD. In no event will you be permitted to reduce your FSA election to a point where the total contributions for the Plan Year are less than the amount already reimbursed for that Plan Year. Qualifying Events and the effective dates for the permitted mid-Plan Year election changes are as follows:

A. Events that may permit an Employee to terminate and/or elect the FSA mid-Plan Year:

1. Birth, adoption, placement for adoption, court or administrative orders requiring dependent coverage = Date of the event or order.

2. Marriage, divorce, death of Spouse, termination of Spouse's or dependent's employment = 1st day of the 1st month from the Employee's signature date on the Election Change documentation.

3. One of your dependents satisfies or ceases to satisfy the requirements for coverage due to a change in age.

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

1. Termination of employment (including retirement) = the end of the semi-monthly pay period in which the Employee worked.

2. Death = Date of death.

3. Commencement of employment by Spouse or dependent. Employee may cease election if Employee gains eligibility for health coverage under Spouse's or dependent's plan, as of the date the Employee ceases participation.

There are detailed rules on when a change in election is deemed to be consistent with a change in status. In addition, there are laws that give you rights to change health coverage for you, your spouse, or your dependents. If you change coverage due to rights you have under the law, then you can make a corresponding change in your elections under the Plan. If any of these conditions apply to you, you should contact the Plan Administrator.

All election change documentation must be signed by the Employee within 35 days of the date of the Qualifying Event. Election change documentation regarding Qualifying Events dealing with the 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.

LEAVES OF ABSENCE

Subject to certain conditions, the Family and Medical Leave Act (FMLA) entitles you to take an unpaid leave of absence totaling 12 weeks per year for specific personal or family health and child care needs. If you take leave under the FMLA, you may revoke or change your existing elections for the FSA. For the FSA, you may continue your coverage, or you may revoke your coverage and resume it when you return. If your FSA terminates, due to your revocation of the benefit while on FMLA or due to your non-payment of contributions, you will be permitted to reinstate coverage for the remaining part of the Plan Year upon your return. You can resume your coverage at its original level and make payments for the time that you are on leave. For example, if you elect $1,200 for the year and are out on leave for 3 months, then return and elect to resume your coverage at that level, your remaining payments will be increased to cover the difference—from $100 per month to $150 per month. Alternatively, your maximum amount will be reduced proportionately for the time that you were gone. For example, if you elect $1,200 for the year and are out on leave for 3 months, your amount will be reduced to $900. The expenses you incur during the time you are not participating in the FSA are not reimbursable.

If you continue your coverage during your unpaid leave, you may pre-pay for the coverage, you may pay for your coverage on an after-tax basis while you are on leave, or you and your Employer may arrange a schedule for you to "catch up" your payments when you return. Note, you will lose coverage if you fail to return to work at the end of the leave or give earlier notice that you will not be returning to active employment.

The taking of leave under FMLA does not constitute a Qualifying Event for the purposes of continuing coverage under COBRA. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost). Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

With respect to other (non-FMLA) unpaid leaves of absence, your coverage under the FSA will terminate.

If an Employee is on approved Leave Without Pay (LWOP), the FSA will terminate at the end of the semi-monthly billing period that the Employee did not work. All funds in the FSA upon termination will be forfeited.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

The Uniformed Services Employment and Reemployment Rights Act (USERRA) protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits Employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services. Under USERAA, you have the following protections:

- If you leave your job to perform military service, you have the right to elect to continue your existing Employer-based health plan coverage for you and your dependents for up to 24 months while in the military.

- Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your Employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

The Plan will continue to reimburse you or your family for eligible medical expenses (except for any illness or injury suffered by you in connection with duty in the uniformed services) for the first 30 days of your absence. However, coverage after that period will be suspended while you are on approved military service leave, unless you opt to continue coverage under the Plan in accordance with the COBRA procedures as set forth in Appendix 5. No re-entry requirements will be imposed if you return to active employment within 30 days of taking leave of employment for duty in the uniformed services.

The "uniformed services" are the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency.

USERRA affords other rights and protections including reemployment rights and the right to be free from discrimination and retaliation. To view the complete notice of your rights under USERRA, go to http://www.dol.gov/vets/programs/userra/USERRA_Private.pdf.

EMPLOYEE EFFECTIVE DATE OF COVERAGE

You must elect the FSA electronically or using forms acceptable to the Plan Administrator.

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.

TERMINATION OF COVERAGE

Upon your termination of employment, your participation in the FSA will cease, and no further salary reduction contributions will be made to your FSA. However, you will be able to submit claims for health care expenses that were incurred before the end of the period for which payments to the FSA have already been made.

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

- The date that you make an election not to participate in accordance with this Plan;
- The date that you no longer satisfy the Eligibility requirements of this Plan;
- The last day of the semi-monthly pay period in which you terminate employment (including retirement) with the Employer;
- The date of the Employee's death;
- The Employee fails to enroll in the FSA for a period of two years, even if there is a carryover balance; or
- The date that the Plan is either terminated or amended to exclude you or the class of Employees of which you are a member.

In accordance with federal law, you will have the opportunity to continue to be covered under the Plan beyond the date that participation would otherwise end. Your COBRA continuation rights and responsibilities are described in Appendix 5 of this SPD.

MODIFICATIONS TO THE PLAN

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

If the Plan is terminated, your FSA will be used to provide benefits through the end of the Plan Year in which termination occurs. It is also possible that future changes in state or federal tax laws may require that the Plan be amended accordingly.

REIMBURSEMENT

CONTRIBUTIONS

Only the Employee may contribute to the FSA. The Employer does not contribute funds to the FSA. Upon eligibility or annually at open enrollment, you may elect to contribute an amount (divisible by 24 or the remaining number of pay periods in the Plan Year if the Employee is a new hire, and up to maximum of $2,850) that will be redirected from your compensation to fund the FSA.

The FSA enables you to pay for expenses allowed under Sections 105 and 213(d) of the Code which are not covered by your medical plan and save taxes at the same time. The FSA allows you to be reimbursed for expenses incurred by you, your Spouse, and your dependents.

A minimum of $50, up to a maximum of $610 of any unused amounts remaining at the end of the Plan Year may be carried over for use in the subsequent Plan Year. Any amounts over $610 at the end of the Run-Out period and after all claims have been paid will be forfeited. Unused Health FSA amounts under $50 will not carry over to the subsequent plan year and will be forfeited.

If you fail to re-enroll in your Health FSA for two consecutive years, then your Health FSA will be terminated, and any balance in your FSA will be forfeited. Please see the "Unused FSA Funds" section below, for more information.

Because it is possible that you might forfeit amounts in the Plan if you do not fully use the contributions that have been made, it is important that you decide how much to place in each account carefully and conservatively. Remember, you must decide which benefits you want to contribute to and how much to place in each account before the Plan Year begins.

ELIGIBLE EXPENSES

Only medical expenses that have not been or will not be reimbursed by any other source are eligible expenses that may be paid or reimbursed under the FSA.

An "eligible expense" means a medical expense as authorized by Code Section 213(d) *incurred* by you, your Spouse, or your eligible dependents that are not otherwise covered by insurance including co-pays, coinsurance, and deductibles. An "eligible expense" does not include health insurance premiums or premiums paid for other types of insurance including COBRA, Medicaid, Medicare, or long-term care insurance.

For purposes of the Plan, you are considered to have "incurred" an expense when the health care services are rendered for which you are seeking a reimbursement, and not when you have actually paid the bill. Please note that it is *not* necessary that you have actually paid an amount due for an eligible medical or dental expense—only that you have *incurred* the expense, and that it is not being paid for or reimbursed from any other source. However, 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.

Eligible expenses must have been incurred after the date the Plan became effective. You may not be reimbursed for any expenses arising before the Plan became effective, or prior to the time you

became covered under the Plan, if later. Further, an expense is not an eligible expense if it is incurred after the date the coverage under the FSA ends.

You may not submit a claim for a medical expense that has been deducted on your prior year's personal tax return, nor shall you be entitled to submit a claim for any other expenses that have been paid through any other health insurance plan, Section 125 "cafeteria" plan, or other similar medical expense reimbursement arrangement.

Please review the list of examples of eligible medical expenses in Appendix 4 for assistance in determining what is generally accepted as an "eligible expense." For a more complete list of eligible medical expenses, visit www.healthequity.com.

Flexible Spending Account (FSA): If your Employer offers an FSA program, with the exception of "limited benefits" that may be paid concurrently, any eligible expense that can be paid under the FSA program must be exhausted before reimbursements will be made from an HRA.

CLAIM REIMBURSEMENT

When you incur an eligible expense, you must submit a claim reimbursement request to the Spending Account Administrator within the time frames specified under the *Claims Instructions* outlined in Appendix 1 of this SPD. If the Spending Account Administrator determines that your claim is valid, you will be reimbursed for your eligible expenses as soon as is administratively feasible after it has been submitted.

You may submit a claim for any eligible expense arising during the Plan Year at any time during the period that begins when the expense is incurred. Remember, though, you can't be reimbursed for any total expenses above the amount contributed by you plus any unused carryover amounts from the previous Plan Year.

To have your claims processed as soon as possible, please read and follow the *Claims Instructions* in Appendix 1 of this SPD.

Amounts reimbursed from the Plan may not be claimed as a deduction on your personal income tax return. Reimbursements made from the Plan are not considered deferred compensation and are generally not subject to income tax or withholding. Reimbursement made from the Plan are not subject to Social Security taxes.

OVERPAYMENTS OR REIMBURSEMENT ERRORS

If it is later determined that you, your Spouse, or your covered dependent(s) received an overpayment or a payment was made in error (i.e., you were reimbursed for an expense under the Plan that is later paid for by some other medical plan), you will be required to refund the overpayment or erroneous reimbursement to the Plan.

If you do not refund the overpayment or erroneous payment, the Plan Administrator 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 include the amount on your

W-2 as gross income. In addition, if the Plan Administrator determines that you have submitted a fraudulent claim, the Plan Administrator may terminate your coverage under this Plan (and to the extent permissible, under any applicable Employer group health plan).

MAXIMUM AMOUNT OF REIMBURSEMENT

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

DENIED CLAIMS

You will be notified in writing by the Spending Account Administrator within 30 days of the date you submitted your claim if the claim is denied unless special circumstances require an additional 15 days to review the 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 Spending Account 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. If you do not receive notification of the denial of a claim within the 30-day period, then if the claim is not otherwise paid, it will be deemed denied.

The notification will set out the reasons your claim was denied, and further advise you of what steps, if any, you might take to validate the claim. It will further advise you of your right to request an administrative review of the denial of the claim; you may request a review any time within the 180-day period after you have received notice that the claim was denied. You or your authorized representative will have the opportunity to review any important documents held by the Administrator, and to submit comments and other supporting information. In most cases, a decision will be reached within 60 days of the date of your request for a review.

See Appendix 1 below for more information regarding your rights to appeal any adverse claim determination.

UNUSED FSA FUNDS

A minimum of $50, up to a maximum of $610, in FSA dollars remaining in your FSA account at the end of the Plan Year will carry over to the next Plan Year. Any applicable carryover funds will be allocated to your FSA after the Run-Out period.

Any monies over the $610 permitted carry over amount that remain at the end of the Plan Year will be forfeited. Unused FSA amounts under $50 will not carry over to the subsequent Plan Year and will be forfeited. Qualifying expenses that you incur late in the Plan Year for which you seek reimbursement after the end of such Plan Year will be paid first before any amount is forfeited. For the FSA, you must submit claims no later than 90 days after the end of the Plan Year.

Additionally, a Health FSA with a balance that is carried over for two consecutive Plan Years, including the Run-Out Period (described below) of the second year, will be terminated and the balance forfeited; provided there have been no new elections for the Health FSA during those two Plan Years. This forfeiture will occur at the end of the Run-Out Period of the second Plan Year. The termination of the Health FSA will not be considered a termination of participation or otherwise affect eligibility or participation in the Plan.

Any funds that you are not entitled to carry over will be forfeited and retained by the Plan Sponsor.

PLAN ACCOUNTING

The Spending Account Administrator may periodically furnish you with a statement of your FSA for you to use in determining how much additional benefits remain in your account prior to the end of the Plan Year. The statement may also assist in budgeting for expense reimbursement needs in future Plan Years.

The statement of benefits may be provided exclusively in an electronic format. You may also make a written request to receive a copy of your FSA reimbursement account statement from the Spending Account Administrator at any time.

APPENDIX 1 – CLAIMS INSTRUCTIONS

No benefit shall be paid hereunder unless a Participant has first submitted a written claim for benefits to the Spending Account Administrator on a form specified by the Spending Account Administrator, or as otherwise set out below. Upon receipt of a properly documented claim, the Spending Account Administrator shall pay the Participant the benefits provided under this Plan as soon as is administratively feasible. A Participant may submit a claim for reimbursement for an eligible expense arising during the Plan Year at any time during the period that begins when the expense is incurred but before any applicable Run-Out period.

The Participant may not submit a claim that is attributable to any prior taxable year or any claim that was incurred before the individual became eligible for coverage under this Plan, or which has already been paid through any other health insurance plan, Section 125 "cafeteria" plan, or other similar medical expense reimbursement arrangement.

CLAIM SUBMISSION

Two types of documentation are usually acceptable to the Spending Account Administrator as substantiation of any claim request:

First, you must submit your claims under any insurance plan under which the person receiving the medical service is covered—your own, your Spouse's, and/or your dependent's health, dental, vision care, Medicare, etc. plans. This will result in the insurer sending an Explanation of Benefits (EOB). You may send the EOB as documentation of an unreimbursed out-of-pocket medical, dental, or vision expense. Second, for unreimbursed out-of-pocket medical, dental, or vision expenses not covered by insurance and not documented by an EOB, you may submit a provider statement of the expenses, including the name of the recipient of the service, date of the service, description of the service, cost of the service, and the name and address of the provider. You must also fill out a form provided to you by the Spending Account Administrator.

a) The Spending Account Administrator will process your claim, deduct the money from your Account, and send you a check in payment of your claim. The Spending Account Administrator issues checks as soon as reasonably practicable, but no less than monthly. If your claim request is denied, you will be notified of this denial under procedures further discussed and set forth below.

b) As an alternative to the method of payment referenced in subsection a) above, if an eligible Employee agrees to the terms and conditions of any applicable cardholder agreement that provides for the payment of eligible expenses through use of a debit card, credit card, other stored value card or other similar electronic media (hereinafter the "Debit Card"), payments under this Plan shall be made directly to the service provider, authorized merchant, or other independent third party that provides products or services that are eligible for payment of eligible expenses as otherwise set forth herein.

(i) Within the cardholder agreement, the eligible Employee agrees that payment for eligible expenses can only be made on behalf of the Employee, the Employee's Spouse or other qualifying dependents and is otherwise limited to the maximum dollar amount of coverage that is otherwise specified for that Benefit in accordance with the limitations set forth in the Employer's signed adoption agreement or as otherwise specified by the Employee's signed election. The Employee also certifies that any expense paid with the card has not been, and will not be, reimbursed through any other plan or method of coverage provided under this Plan. The cardholder also understands that the certification, which shall be printed on the back of the Debit Card, is reaffirmed each time the card is used. The cardholder also agrees to acquire and retain sufficient documentation for any expense(s) paid with the card, including invoices and receipts where appropriate or as required by law. The cardholder also understands that the Debit Card is automatically cancelled upon ceasing to participate in the Plan, or under such other situations that are otherwise set forth within the cardholder agreement itself.

(ii) Unless other more stringent procedures or requirements are implemented and communicated to the Employer and its Employees, the Spending Account Administrator agrees that it shall adhere to the terms and conditions of any separate Employer cardholder servicing agreement, including but not limited to a requirement to maintain the program in compliance with applicable standards under the Internal Revenue Code and any mandates that payments for eligible expenses only be made to authorized merchants and service providers. The Spending Account Administrator also agrees that it shall establish and maintain procedures for substantiation of any payments after the card has been used for eligible expense payments that are in accordance with applicable provisions of the Code, any underlying regulations and other applicable guidance thereunder.

(iii) If any claim reimbursement request is being submitted in a manner other than as specified under any of the methods allowable under existing IRS guidelines, the Spending Account Administrator may make a conditional payment of an allowable eligible expense reimbursement item to the authorized service provider, merchant, or approved independent third party, but shall also require the cardholder to remit additional third-party information, such as merchant or service provider receipts, describing the service or product, the date of service or sale, and the amount, which shall be subject to further review and substantiation.

(iv) If any conditional payment has been made but is subsequently deemed not to be an eligible expense reimbursement, the Spending Account Administrator shall ensure that proper correction procedures are maintained with respect to the improper payment(s):

(A) Upon identification of any improper payment, the Spending Account Administrator shall require the Employee to pay back to the Plan an amount equal to the improper payment;

(B) To ensure that no further violations occur, the Spending Account Administrator shall deactivate the debit card until the improper payment is recovered or repaid by the Employee;

(C) If the Employee does not immediately repay the Plan, the Spending Account Administrator may take such action as necessary to ensure that the proper amount is withheld from the Employee's wages or other compensation (with such amounts then being immediately remitted to the Plan by the Employer) to the extent consistent with applicable law;

(D) To the extent that neither (A) or (B) above are allowable or effective, the Spending Account Administrator shall have the authority to utilize a claim substitution or offset approach to resolve the improper claim amount(s), with such methodology being clearly explained to the Employee-cardholder as part of his Employee cardholder agreement; and

(E) The Spending Account Administrator may also pursue any other methods of collection as would be consistent with its usual business practices to ensure the improper payment amounts are adequately remitted to the Plan as required by the Plan or Employee cardholder agreement.

(v) If a cardholder attempts to utilize the Debit Card for any improper or non-allowable purpose, the Participant/cardholder shall be responsible for any and all fees or other expenses, including restitution or other similar penalty amounts, charged inappropriately by the Participant/cardholder.

CLAIMS PROCESS

You should submit reimbursement claims during the Plan Year, but in no event later than the Run-Out period described in the "General Information About Our Plan." Any claims submitted after that time will not be considered. Claims for benefits that are insured will be received in accordance with procedures contained in the policies. All other general claims or requests should be directed to the Spending Account Administrator of the Plan. If a non-insured claim under the Plan is denied in whole or in part, you or your beneficiary will receive written notification. The notification will include:

a) Information sufficient to identify the claim involved, including the date of the service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
b) The reasons for the denial;
c) Reference to the specific provisions of the Plan on which the denial was based; and
d) A description of any additional material or information needed to further process the claim and an explanation of why such material or information is necessary.

Within 60 days after denial, you or your beneficiary may submit a written request for reconsideration of the denial to the Administrator.

Any such request should be accompanied by documents or records in support of your appeal. You or your beneficiary may review pertinent documents and submit issues and comments in writing. The Spending Account Administrator will review the claim and provide, within 60 days, a written response to the appeal. (This period may be extended an additional 60 days under certain circumstances.) In this response, the Spending Account Administrator will explain the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based. The Spending Account Administrator has the exclusive right to interpret the appropriate plan provisions. Decisions of the Spending Account Administrator are conclusive and binding.

APPENDIX 2 – OTHER NOTICES

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

Under federal law, group health plans generally may not restrict benefits for a hospital 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 (or 96, as applicable) hours. In any case, health insurance plans may not require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 (or 96) hours.

HIGHLY COMPENSATED EMPLOYEES

Under the Internal Revenue Code, if you are deemed to be a "Highly Compensated Employee", the amount of contributions and benefits for you may be limited so that the Plan as a whole does not unfairly favor those who are highly paid, their Spouses or their dependents. Your own circumstances will dictate whether contribution limitations on "highly compensated Employees" will apply. You will be notified of these limitations if you are affected.

NO EMPLOYMENT RIGHTS CONFERRED

Neither this Plan nor any action taken with respect to it shall confer upon any person the right to be continued in the employment of the Employer.

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.

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 aged 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, health insurance coverage through KEHP will be primary to Medicare when you have elected such coverage and have current employment status.

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

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.

For additional information regarding WHCRA, visit kehp.ky.gov.

MENTAL HEALTH PARITY

This Plan operates in compliance with Mental Health Parity Act and the Additional Equity Act of 2008.

THE GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (GINA)

This Plan is compliant with the Genetic Information Nondiscrimination Act of 2008.

SOCIAL SECURITY BENEFITS

Your Social Security benefits may be slightly reduced because when you receive tax-free benefits under this Plan, it reduces the amount of contributions that you make to the Federal Social Security system as well as your Employer's contribution to Social Security on your behalf.

APPENDIX 3 - HIPAA

Title II of the Health Insurance Portability and Accountability Act of 1996 and the regulations at 45 CFR Parts 160 through 164 ("HIPAA"), contain provisions governing the use and disclosure of Protected Health Information by health plans, and provide privacy rights to Participants in those plans. HIPAA applies to this Plan.

Protected Health Information or "PHI" is health information that is created or received by the Plan. PHI relates to your physical or mental health or condition, the provision of health care to you, or the payment for the provision of health care to you. Typically, the information identifies you, your diagnosis, and treatment or supplies used in the course of your treatment. "Electronic Protected Health Information" (also known as "ePHI") is PHI stored in any electronic media, including any memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card or the transmission or exchange of information through usage of the internet (wide-open), extranet (using internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/ transportable electronic storage media, but does not include facsimile or voice transmissions and is limited to the information created, maintained, transmitted, or received by or on behalf of the Plan.

The Plan may disclose PHI to your Employer only for limited purposes as described in KEHP's Notice of Privacy Practices which can be found at kehp.ky.gov, under the Docs, Forms, and Legal Notices link. The Employer agrees to use and disclose PHI only as permitted or required by the Plan's documents or as required by HIPAA. PHI or ePHI may be used or disclosed for plan administration functions that the Employer performs on behalf of the Plan. Such functions include:

- Enrollment of eligible Employees and their eligible dependents
- Eligibility determinations
- Payment for coverage
- Claim payment activities
- Coordination of benefits
- Claim appeals

The Plan shall maintain policies and procedures that govern the Plan's use and disclosure of PHI. These policies and procedures include provisions to restrict access solely to the above individuals and only for the functions listed above. The Plan's policies and procedures also include a mechanism for resolving issues of noncompliance.

HIPAA NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW IT CAREFULLY.

Purpose.
This notice is intended to inform you of the privacy practices followed by your Employer and other affiliated entities (the "Employer"), which provide an FSA. It also explains the federal privacy rights afforded to you and the members of your family as plan Participants covered under a group health plan.

As a plan sponsor, your Employer may need access to health information in order to perform plan administrator functions. We want to assure the plan Participants covered under our group health plan that we comply with federal privacy laws and respect your right to privacy. We require all members of our workforce and third parties that are provided access to health information to comply with the privacy practices outlined below.

Uses and Disclosures of Health Information.

Health Care Operations. We use and disclose health information about you in order to perform plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand Participant utilization and to make plan design changes that are intended to control health care costs.

Payment. We may also use or disclose identifiable health information about you without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered. For example, a health care provider that provided treatment to you will provide us with your health information. We use that information in order to determine whether those services are eligible for payment under our group health plan.

Treatment. Although the law allows use and disclosure of your health information for purposes of treatment, as a plan sponsor we generally do not need to disclose your information for treatment purposes. Your physician or health care provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and health care operations.

As permitted or required by law. We may also use or disclose your health information without your written authorization for other reasons as permitted by law. We are permitted by law to share information, subject to certain requirements, in order to communicate information on health- related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g., preventing the spread of disease) without your written authorization. We are also permitted to share health information during a corporate restructuring such as a merger, sale, or acquisition. We will also disclose health information about you when required by law, for example, in order to prevent serious harm to you or others.

Pursuant to your Authorization. When required by law, we will ask for your written authorization before using or disclosing your identifiable health information. If you choose to sign an

authorization to disclose information, you can later revoke that authorization to cease any future uses or disclosures.

Right to Inspect and Copy. In most cases, you have a right to inspect and copy the health information we maintain about you.

Right to an Accounting of Disclosures. You have a right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment, health care operations, or pursuant to your written authorization.

Right to Amend. If you believe that information within your records is incorrect or if important information is missing, you have a right to request that we correct the existing information or add the missing information.

Right to Request Restrictions. You may request in writing that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request but, we are not legally obligated to agree to those restrictions.

Right to Request Confidential Communications. You have a right to receive confidential communications containing your health information. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.

Right to Receive a Paper Copy of this Notice. If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact the Plan Administrator.

Legal Requirements. We are required by law to protect the privacy of your information, provide this notice about information practices, and follow the information practices that are described in this notice.

We may change our policies at any time. Before we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our notice at any time. For more information about our privacy practices, or if you have any questions or complaints, please contact your Plan Administrator.

Filing a Complaint. If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the Plan Administrator. You also may send a written complaint to the U.S. Department of Health and Human Services — Office of Civil Rights (OCR). Information about filing a complaint with OCR can be found at www.hhs.gov/ocr.

Please see the Kentucky Employees' Health Plan Notice of Privacy Practices at kehp.ky.gov, under the Docs, Forms, and Legal Notices link, for additional information on your HIPAA privacy rights and how KEHP may use your information.

APPENDIX 4- ELIGIBLE EXPENSES

Your FSA will pay for or reimburse you for eligible medical expenses, as defined in Code Section 213(3), that are incurred by you, your Spouse, or your dependent(s) during the coverage period.

ALLOWABLE EXPENSES

Below are a few examples of expenses that may be paid for or reimbursed by your FSA. For more information on allowable expenses, visit healthequity.com.

Dental

- Dental Co-insurance
- Dental Co-payment
- Deductible for dental plan
- Dental Care for non-cosmetic purposes
- Orthodontia
- X-rays

Medical

- Medical Co-insurance
- Medical Co-payment
- Deductible for medical plan
- Certain over-the-counter medications
- Chiropractic office visits and treatment
- Feminine Products
- Certain protective equipment such as face masks and hand sanitizer
- Flu shots
- Hearing aids and batteries
- Hospital services and fees
- Laboratory fees
- Medical Equipment
- Occupational therapy
- Office visits
- Prescription co-insurance
- Prescription co-payment
- Psychiatric Care
- Speech therapy
- Wheelchair
- X-ray fees

Vision

- Vision co-insurance
- Vision co-payment
- Eyeglasses

- Laser eye surgery
- Lasik
- Office visits
- Prescription sunglasses
- Eye drops and treatment

DISALLOWED EXPENSES

Below are a few examples of expenses that may not be paid for or reimbursed by your FSA. For more information on disallowed expenses, visit healthequity.com.

- Cosmetic procedures or surgery
- Over-the-counter healthcare and dental care products
- Hair removal and transplants
- No show fees charged by health care providers
- Personal use items (toothbrush, toothpaste)
- Sunscreen.
- Insurance policy premiums
- Long-term care premiums
- Medicare Part B premiums
- COBRA premiums
- Fees for exercise, athletic, or health club membership, when there is no specific health reason for membership
- Payments for child care

APPENDIX 5- COBRA

*** VERY IMPORTANT NOTICE ***
(APPLIES TO GROUPS WITH 20 OR MORE EMPLOYEES)

CONTINUATION COVERAGE RIGHTS UNDER COBRA

INTRODUCTION

A federal law was enacted (Public Law 99-272, Title X) requiring that most Employers sponsoring group health plans offer Employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage"), at group rates, in certain instances where coverage under the plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

Both you and your Spouse should take the time to read this notice carefully.

The Plan Administrator or its designee is responsible for administering COBRA continuation coverage. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA. While the FSA itself is not a group health plan, it does provide health benefits. Whenever "Plan" is used in this section, it means any of the health benefits under this Plan including the Health FSA. Only an Employee may choose COBRA continuation coverage for a Health FSA.

CONTINUATION COVERAGE FOR EMPLOYEE (COBRA)

If your Employer is subject to COBRA, you, as an Employee of that Employer, have the right to continue coverage under your current Plan if your coverage is lost due to any of the following qualifying events:

1. Termination of employment (for reasons other than gross misconduct.)

2. Involuntary termination of Employee.

3. Reduction in hours of employment.

CONTINUATION COVERAGE FOR SPOUSE OF EMPLOYEE

As a Spouse of a covered Employee, you have the right to continue coverage under your current Plan if your coverage is lost due to any of the following qualifying events:

1. A termination of your Spouse's employment (for reasons other than gross misconduct).

2. Reduction in your Spouse's hours of employment.

3. The death of your Spouse.

4. Divorce or legal separation from your Spouse.

5. Your Spouse becomes entitled to Medicare.

Only a Qualified Beneficiary who is an Employee may elect to continue the Health FSA under COBRA. A Spouse who is a Qualified Beneficiary may not elect the Health FSA under COBRA.

CONTINUATION COVERAGE FOR DEPENDENT OF EMPLOYEE

As a dependent child of a covered Employee, you have the right to continue coverage under your current Plan if your coverage is lost due to any of the following qualifying events:

1. The termination of an Employee parent's employment (for reasons other than gross misconduct).

2. Reduction in an Employee parent's hours of employment with his/her current Employer.

3. The death of your Employee parent.

4. Parent's divorce or legal separation.

5. Employee parent becoming entitled to Medicare.

6. You cease to be a "dependent child" under the current health plan(s).

Only a Qualified Beneficiary who is an Employee may elect to continue the Health FSA under COBRA. A Dependent who is a Qualified Beneficiary may not elect the Health FSA under COBRA.

NOTIFICATION AND PREMIUMS

Under this law, it is <u>your</u> responsibility to inform us of a divorce, legal separation, or a child losing dependent status under the Plan(s) within 60 days of the occurrence of the event. You must also notify us within 60 days of receiving a disability determination letter from the Social Security Administration. Upon the occurrence of a qualifying event, you will be notified of your right to continue coverage under your current Plan(s). If you elect continuation coverage you must do so, in writing, within 60 days from the later of the notice or the date of the qualifying event/loss of coverage.

The recipient of coverage may have to pay part or all of the cost of coverage, which cannot exceed 102 percent of the cost under the group plan. If, during the continuation period, rates change for the Employer group, persons under COBRA are subject to that increase.

You will have a 45-day period from the date you elect continuation coverage to pay the initial premium. This premium must include the entire amount due from the date you would have lost coverage to the date of the election. Thereafter, you will be given a grace period of not less than 30 days to pay premiums.

Note that these notification and payment deadlines for COBRA are subject to change under applicable laws and regulator guidance. Please refer to your COBRA notification letter for details.

If you choose continuation coverage, your Employer is required to give you coverage that is identical to the coverage provided under the plan to similarly situated Employees or family members.

You do not have to show that you are insurable to choose continuation coverage.

If you do not choose continuation coverage, your group health plan coverage will end as of the date of the qualifying event.

If a qualified beneficiary dies or becomes incapacitated during the election period, he or she may not be able to elect coverage timely. A legally appointed guardian can make the election and act for the qualified beneficiary. However, there may not be adequate time during the 60-day election period. Therefore, the election period can be extended until a legally appointed guardian is designated. This extension of the time period is referred to as "tolling".

TERMINATION OF RIGHTS

If you choose continuation coverage, the law provides that coverage may be terminated for any of the following reasons:

1. Your Employer terminates all group health coverage provided to its Employees;

2. The premium for your continuation coverage is not paid in full within the time prescribed under the Notifications and Premiums section of this notice;

3. You are or become covered under another group health plan other than the plan of the Employer providing continuation, as long as no exclusionary period will be imposed on a preexisting condition; or

4. You are or become entitled to Medicare. However, if it is determined that Medicare is to be the secondary payer, your continuation coverage under your current health plan(s) is primary until Medicare becomes primary, or continuation coverage is otherwise terminated, whichever is earlier.

ADDITIONAL INFORMATION

If you have questions about your right to continue coverage under your current health Plan(s), please contact the Plan Administrator or the Plan's COBRA Administrator.

If you change your address or marital status, or become entitled to Medicare or another group health plan while you are covered under the Plan, please notify your Plan Administrator.

QUALIFIED BENEFICIARIES

The term Qualified Beneficiary refers to individuals who are covered under the Employee's group health plan the day before a COBRA qualifying event takes place. According to the COBRA statutes, a Qualified Beneficiary is the covered Employee, covered Spouse of the Employee, covered dependent child of the Employee **OR** any child born to, or placed for adoption with the covered Employee during the period of continuation coverage.

AFFECT OF COBRA ON YOUR HEALTH FSA

An Employee can elect to continue participation in the FSA for the remainder of the Plan Year, subject to the following conditions. You may only continue to participate in the FSA if you have elected to contribute more money than you have taken out in claims. For example, if you elected to contribute an annual amount of $500 and, at the time you terminate employment, you have contributed $300 but only claimed $150, you may elect to continue coverage under the HealthFlexible Spending Account. If you elect to continue coverage, then you would be able to continue to receive your health reimbursements up to the $500. However, you must continue to pay for the coverage, just as the money has been taken out of your paycheck, but on an after-tax basis. The Plan can also charge you an extra amount (as explained above for other health benefits) to provide this benefit.

APPENDIX 6 - DEFINITIONS

Employee – means:

(1) a person, including an elected public official, who is regularly employed by any department, office, board, agency, or branch of state government; or by a public postsecondary educational institution; or by any city, urban-county, charter county, county, or consolidated local government, whose legislative body has opted to participate in the state-sponsored health insurance program pursuant to KRS 79.080; and who is a contributing member to any one (1) of the retirement systems administered by the state; or, in the case of a public postsecondary education institution, is an individual participating in an optional retirement plan authorized by KRS 161.567; or is eligible to participate in a retirement plan established by an employer who ceases participating in the Kentucky Public Pensions Authority pursuant to KRS 61.522 whose employees participated in the health insurance plans administered by the Personnel Cabinet prior to the employer's effective cessation date in the Kentucky Public Pensions Authority. See KRS 18A.225 and KRS 18A.227; and

(2) a certified or classified employee or elected member of a board of education.

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 elects to contribute funds to the Health FSA.

Plan – means this Plan, as set forth herein.

Plan Administrator – means the Commonwealth of Kentucky, Personnel Cabinet, Department of Employee Insurance who has the authority, discretion, and responsibility to manage and direct the operation and administration of the Plan.

Plan Manager or Spending Account Administrator – means HealthEquity/WageWorks, Inc.

Plan Sponsor – means the Commonwealth of Kentucky.

Plan Year – shall be the period of coverage beginning January 1 and ending December 31.

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.

Spouse – means a person to whom an Employee is legally married.

Summary Plan Description or "SPD" – means the Health FSA SPD and all appendices incorporated into and made a part of the SPD that is adopted by the Employer and as may be amended from time to time.

SUMMARY

The money you earn is important to you and your family. You need it to pay your bills, enjoy recreational activities, and save for the future. The FSA will help you keep more of the money you earn by lowering the amount of taxes you pay. The Plan is the result of our continuing efforts to find ways to help you get the most for your earnings.

If you have any questions, please contact the Spending Account Administrator or the Plan Administrator.