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COMMONWEALTH OF KENTUCKY

KENTUCKY EMPLOYEES' HEALTH PLAN (KEHP)

HEALTHCARE FLEXIBLE SPENDING ACCOUNT

SUMMARY PLAN DESCRIPTION

Louisville Plan Number: 236117

Lexington Plan Number: 236134

Northern Kentucky Plan Number: 236215

Effective Date: January 1, 2013

Plan Year: January 1, 2013 through December 31, 2013

Employer's Federal Tax Identification Number: 61-0600439

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INTRODUCTION

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

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

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

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PLAN INFORMATION

GENERAL INFORMATION ABOUT THE PLAN

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

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

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

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

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

PLAN CONTACT INFORMATION

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

Employer / Plan Sponsor

Commonwealth of Kentucky
Personnel Cabinet, Department of Employee Insurance
501 High Street
Second Floor
Frankfort, KY 40601
888-581-8834
502-564-6534

Plan Administrator

Commonwealth of KY
Personnel Cabinet, Department of Employee Insurance
501 High Street
Second Floor
Frankfort, KY 40601
888-581-8834
502-564-6534

Humana / *Plan Manager*

Humana
Attn: Humana Spending Account Administration Team
PO Box 14167
Lexington KY 40512-4167
Toll Free: 800-604-6228
Fax: 800-905-1851

PARTICIPATION

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

"Employee" shall mean a person, including an elected public official, who is regularly employed by any department, board, agency, or branch of state government, and who is a contributing member to any one (1) of the retirement systems administered by the state. See KRS 18A.225 and 18A.227.

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

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

ENROLLMENT

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

(i) Satisfies the Cafeteria Plan Eligibility Requirements and

(ii) Is also eligible to participate in any of the Benefit Plan Options will be eligible to participate in this Cafeteria Plan.

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

The Cafeteria Plan has three election periods:

(i) The "Initial Election Period," (Upon Hire)

(ii) The "Annual Election Period," (Open Enrollment) and

(iii) The "Election Change Period", which is the period following the date you have a *Qualifying Event*.

The following is a summary of the Initial Election Period and the Annual Election Period.

THE INITIAL ELECTION PERIOD

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

THE ANNUAL ELECTION PERIOD

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

ELECTION CHANGES

If you experience a Qualifying Event as described in the Cafeteria Plan Summary, you may make the permitted election changes if you complete and submit an election change form within thirty-five (35) days after the date of the event, unless the event is for birth of a newborn, or adoption or placement for adoption, in which you have sixty (60) days from the date of birth, adoption or placement for adoption to submit an election change form.

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

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

(i) You experience a "*Qualifying Event*" that affects your eligibility under this Cafeteria Plan and/or a Benefit Plan Option; and

(ii) You complete and submit a written Election Change Form within the Election Change period.

Qualifying Events are recognized by this Cafeteria Plan. Please contact your employer or Insurance Coordinator for additional information concerning this Plan's Qualifying Events.

If coverage under a Benefit Plan Option ends, the corresponding Pre-tax Contributions for that coverage will automatically end.

See Section 26 C.F.R. § 1.125 – 4 and Prop. Treas. Reg 1.125-2(a).

LEAVE OF ABSENCE

The following is a general summary of the rules regarding participation in the Cafeteria Plan (and the Benefit Plan Options) during a leave of absence:

The specific election changes that you can make under this Cafeteria Plan following a leave of absence are:

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

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

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

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

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

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

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

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

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

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

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

TERMINATION OF COVERAGE

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

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

(i) The date that you make an election not to participate in accordance with this Cafeteria Plan Summary;

(ii) The date that you no longer satisfy the Eligibility Requirements of this Cafeteria Plan;

(iii) The date that you terminate employment with the *Employer*; or

(iv) The date that the Cafeteria Plan is either terminated or amended to exclude you or the class of *employees* of which you are a member.

If your employment with the *Employer* is terminated during the *Plan Year* or you otherwise cease to be eligible, your active participation in the Cafeteria Plan will automatically cease. You will not be able to make any more *Pre-tax Contributions* under the Cafeteria Plan.

If you are rehired within the same *Plan Year* and are eligible for the Cafeteria Plan (or you become eligible again), you may make new elections if you are rehired or become eligible again 11 days or more after you terminated employment or lost eligibility (subject to any limitations imposed by the Benefit Plan Option(s)). If you are rehired or again become eligible less than 11 days of your termination date, your Cafeteria Plan elections that were in effect when you terminated employment or stopped being eligible will be reinstated and remain in effect for the remainder of the *Plan Year* (unless you are allowed to change your election in accordance with the terms of the Plan).

TRANSFERS

A Clean Transfer is a transfer from one participating entity to another with no break in service days. No election changes are permitted.

A Small Break Transfer is a transfer from one participating entity to another participating entity with a break in service of 1-10 calendar days. Coverage with the new employer will begin on the 1st day of the month following the month of the hire date. No election changes are permitted.

A New Employee Transfer is a transfer from one participating entity to another participating entity with a break in service of 11 or more calendar days. The new hire waiting period applies and election changes and smoking status changes are permitted.

TAX ADVANTAGES

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

	No FSA	With FSA
Annual Salary	$35,000	$35,000
Pre-tax FSA withholding to cover out-of-pocket medical expenses		- $1,000
Taxable Salary	$35,000	$34,000
Approximate Tax at 26%	- $9,100	- $8,840
Take Home Pay	$25,900	$25,160
Out-of-pocket medical expense after taxes	- $1,000	
Money left in your pocket after medical expenses	$24,900	$25,160
Saved by participating in the FSA		$260

HEALTHCARE FSA ELIGIBILITY REQUIREMENTS

PARTICIPATION

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

"Employee" shall mean a person, including an elected public official, who is regularly employed by any department, board, agency, or branch of state government, and who is a contributing member to any one (1) of the retirement systems administered by the state. See KRS 18A.225 and KRS 18A.227.

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

You may also become a participant if you experience a Qualifying Event that permits you to enroll midyear.

ENROLLMENT

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

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

You may elect any annual reimbursement amount subject to the maximum annual Healthcare Reimbursement Amount allowed for the plan. The Maximum Annual Reimbursement Amount each year may not exceed the lesser of the Healthcare FSA reimbursement amount elected for that year or $2,500. The minimum election amount is $120 per year.

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

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

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 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.

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 Healthcare 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.

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 2013, 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 <u>not</u> 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.

The HEART Act

The Heroes Earnings Assistance and Relief Tax Act of 2008 (the "HEART Act") amends Internal Revenue Code Section 125, among other sections, to permit plan sponsors to make a cash distribution of unused health FSA benefits to eligible individuals without disqualifying the cafeteria plan. Under the HEART Act, plan sponsors optionally may amend their health FSA and cafeteria plan documents to allow a distribution of unused health FSA funds from the plan to a qualified military reservist subject to certain conditions. Distributions that meet the requirements are called "qualified reservist distributions."

In order to be a "qualified reservist distribution," the following 4 requirements must be met:

1 A qualified reservist distribution can be made only to a member of a "reserve component" (as defined in section 101 of title 37 of the United States Code). This means a member of the Army National Guard; U.S. Army, Navy, Marine Corps, Air Force, or Coast Guard Reserve; Air National Guard of the United States; or the Reserve Corps of the Public Health Service.

2. The distributions can be made only to a reservist who has been ordered or called into active duty for (i) 180 days or more or (ii) for an indefinite period.

3. The amount of the distribution must be for "all or a portion of the balance in the employee's account."

4. The distribution must be made within the period beginning on the date the reservist is called or ordered to duty and ending on the last day that reimbursements could otherwise be made for the plan year that includes the first day of the distribution period.

ELECTION CHANGES

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

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

(ii) Following a Qualifying Event. You may change your Healthcare FSA election during the Plan Year only if you experience an applicable Qualifying Event.

Qualifying events are governed by 26 C.F.R. § 1.125-4 and Prop. Treas. Reg 1.125-2.

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

(i) The same coverage level in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or

(ii) At the same coverage level that is reduced pro-rata for the period of FMLA leave during which you did not make any contributions.

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

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

CONTINUATION OF BENEFITS

Effective October 13, 1994 Federal law requires that health plans must offer to continue coverage for employees who are absent due to service in the uniformed services and/or their dependents. Coverage may continue for up to twenty-four (24) months after the date the employee is first absent due to uniformed service.

ELIGIBILITY

An employee is eligible for continuation under USERRA if absent from employment because of voluntary or involuntary performance of duty in the Armed Forces, Army National Guard, Air National Guard, the commissioned corps of the Public Health Service or any other category of persons designated by the President of the United States of America in a time of war or national emergency. Duty includes absence for active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty and for the purpose of an examination to determine fitness for duty.

An employee's dependent who has coverage under this Plan immediately prior to the date of the employee's covered absence are eligible to elect continuation under USERRA.

PREMIUM PAYMENT

If continuation of Plan coverage is elected under USERRA, the employee or dependent is responsible for payment of the applicable cost of coverage. If the employee is absent for 30 days or less, the cost will be the amount the employee would otherwise pay for coverage. For absences exceeding 30 days, the cost may be up to 102% of the cost of coverage under this Plan. This includes the employee's share and any portion previously paid by the employer.

DURATION OF COVERAGE

Elected continuation coverage under USERRA will continue until the earlier of:

- 24 months beginning the first day of absence from employment due to service in the uniformed services; or

- The day after the *employee* fails to apply for, or return to employment, as required by USERRA, after completion of a period of service.

Under Federal law, the period of coverage available under USERRA shall run concurrently with the COBRA period available to an *employee* and/or eligible *dependents*.

OTHER INFORMATION

Employees should contact their *employer* with any questions regarding coverage normally available during a military leave of absence or continuation coverage and notify the *employer* of any changes in marital status, or a change of address.

TERMINATION OF COVERAGE

Although the *Employer* expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time and for any reason. Your coverage under the Healthcare FSA ends on the earlier of the following to occur:

(i) The date that you elect not to participate in accordance with the Cafeteria Plan Summary;

(ii) The last day of the *Plan Year* unless you make an election during the Annual Election Period;

(iii) The date that you no longer satisfy the Healthcare FSA Eligibility Requirements;

(iv) The date that you terminate employment; or

(v) The date that the Plan is terminated or you or the class of eligible *employees* of which you are a member are specifically excluded from the Plan.

You may be entitled to elect Continuation Coverage under the Healthcare FSA once your coverage ends because you terminate employment or experience a reduction in hours of employment. Coverage for your Eligible Dependents ends on the earliest of the following to occur:

(i) The date your coverage ends;

(ii) The date that your dependents cease to be eligible dependents (e.g. you and your *spouse* divorce); or

(iii) The date the Plan is terminated or amended to exclude the individual or the class of Dependents of which the individual is a member from coverage under the Healthcare FSA.

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

ELIGIBLE CLAIMS EXPENSE

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

(i) The expense is for "Healthcare" as defined by *Code* Section 213(d), excluding Over-the-Counter drugs and medicines that have not been prescribed;

(ii) The expense has not been reimbursed by any other source and you will not seek reimbursement for the expense from any other source.

The *Code* generally defines "Healthcare" as any amounts incurred to diagnose, treat, or prevent a specific medical condition or for purposes of affecting any function or structure of the body. This includes, but is not limited to, both prescription and Over-the-Counter drugs and Over-the-Counter products and devices (e.g., crutches, supplies such as bandages and diagnostic devices such as blood sugar test kits), but does not include Over-the-Counter drugs and medicines (unless they have been prescribed). Not every health related expense you or your eligible dependents incur constitutes an expense for "Healthcare." For example, an expense is not for "Healthcare", as that term is defined by the *Code*, if it is merely for the beneficial health of you and/or your eligible dependents (e.g. vitamins or nutritional supplements that are not taken to treat a specific medical condition) or for cosmetic purposes, unless necessary to correct a deformity arising from illness, injury, or birth defect. You may, at the discretion of the Humana or the *Plan Administrator*, be asked to provide additional documentation from a Healthcare provider showing that you have a medical condition and/or the particular item is necessary to treat a medical condition. Expenses for cosmetic purposes are also not reimbursable unless they are necessary to correct an abnormality caused by illness, injury or birth defect.

In addition, certain expenses that might otherwise constitute "Healthcare" as defined by the *Code* are not reimbursable under any Healthcare FSA (per IRS regulations):

(i) Health insurance premiums;

(ii) Over-the-Counter drugs and medicines;

(iii) Expenses incurred for qualified long term care services; and

(iv) Any other expenses that are specifically excluded by the *Employer*.

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

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

CLAIMS REIMBURSEMENT

Under this Healthcare FSA, you have two reimbursement options. You can complete and submit a written claim for reimbursement (see "Paper Claims" below for more information). Alternatively, you can use the 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.

FSA 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 Healthcare Expenses at any time prior to the end of the FSA Run Out Period. The FSA Run Out Period for active and terminated *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 FSA that is later paid for by your health plan you will be required to refund the overpayment or erroneous reimbursement to the FSA.

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 FSA.

PAPER CLAIMS

When you incur an Eligible Healthcare 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 the Humana or print a copy from the KEHP website at 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 Healthcare 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 Healthcare Expense, you will receive notification of this determination. You must submit all claims for reimbursement for Eligible Healthcare 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 Healthcare Expenses at the time that you incur the expense. Here is how the Humana*Access* card works.

(a) 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 any fees applicable to participate in the Program, limitations as to card usage, the Plan's right to withhold and offset for ineligible claims, etc.

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

(b) The Humana*Access* 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 thirty (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 paper claims.

(c) As specified in the Cardholder Agreement, you certify during the applicable Election Period that the amounts in your Healthcare FSA will only be used for Eligible Healthcare Expenses (i.e. healthcare 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 card use privileges.

(d) Use of the Humana*Access* card for Health FSA expenses is limited to merchants who are healthcare 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 Health FSA expenses for reimbursement using a paper claim.

(e) When you incur an Eligible Healthcare 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 or debit card. The provider is paid for the expense up to the maximum reimbursement amount available under the Plan (or as otherwise limited by the Program) at the time that you swipe the card. Every time you swipe the Humana*Access* card, you certify to the Plan that the expense for which payment under the Healthcare FSA is being made is an Eligible Healthcare Expense and that you have not been reimbursed from any other source nor will you seek reimbursement from another source.

(f) 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 healthcare provider (e.g., receipt, invoice, etc.) that includes the following information each time you swipe the Humana*Access* card:

(i) The nature of the expense (e.g., what type of service or treatment was provided).
(ii) The date the expense was incurred.
(iii) 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 Humana*Access* card arrangement, a written third party statement is required to be submitted (except as otherwise provided in the Cardholder Agreement). You will receive a letter from the Claims Administrator that a third party statement is needed. You must provide the third party statement to the Claims Administrator within forty-five (45) days (or such longer period provided in the letter from the Claims Administrator) of the request.

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

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

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

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

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

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

(i) You can use either the Humana*Access* card or the 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 Paper Claims approach discussed above. Claims for which the Humana*Access* card has been used cannot be submitted as Paper Claims.

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 FSA (i.e., a claim that qualifies for after-the-fact-substantiation for which proper substantiation is not subsequently provided).

- **DENY ACCESS TO THE HUMANAACCESS 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 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.

DENIED CLAIM

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

UNCLAIMED HEALTHCARE REIMBURSEMENTS

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

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

COBRA CONTINUATION OF COVERAGE

A Federal Law called **Consolidated Omnibus Budget Reconciliation Act (COBRA)** requires most private and governmental Employers sponsoring Group Health Plans to offer Employees and their families the opportunity for a temporary extension of Healthcare coverage (called "Continuation of Coverage") at group rates in certain instances where coverage under the Plans would otherwise end. These rules apply to this Plan unless the Employer sponsoring the Health FSA is not subject to these rules (e.g., the Employer is a "small Employer" or the Health FSA is a church Plan). The Plan Administrator can tell you whether the Employer is subject to Federal COBRA continuation rules (and thus subject to the following rules). These rules are intended to summarize the continuation rights set forth under Federal Law. If the Federal Law changes, only the rights provided under the applicable Federal Law will apply. To the extent that any greater rights are set forth herein, they shall not apply. For additional information regarding your COBRA Continuation of Coverage, please contact the Plan Administrator.

WHEN COVERAGE MAY BE CONTINUED

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

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

	Covered Employee	**Covered Spouse**	**Covered Dependent**
Covered Employee's termination of employment or reduction in hours of employment	√	√	√
Divorce or legal separation		√	
Child ceasing to be an Eligible Dependent			√
Death of the Covered Employee		√	√

HEALTHCARE FSA CONTINUATION OF COVERAGE

NOTICE REQUIREMENTS

You or your Covered Dependents (including your Spouse) must notify the Employer or Insurance Coordinator in writing of a divorce, legal separation, or a child losing dependent status under the Plan within 60 days of the later of (i) date of the event (ii) the date on which coverage is lost because of the event or (iii) the date that you are notified of your obligation to provide notice of such an event through this SPD or the General Notice provided by the Plan Administrator. When the Employer or Insurance Coordinator is notified that one of these events has occurred, the Plan Administrator will in turn notify you that you have the right to choose Continuation of Coverage by sending you the appropriate Election Forms. Notice to an Employee's Spouse is treated as notice to any Covered Dependents who reside with the Spouse. An Employee or Covered Dependent is responsible for notifying the Employer or Insurance Coordinator if he or she becomes covered under another group health Plan.

ELECTION PROCEDURES AND DEADLINES

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

COST

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

WHEN CONTINUATION OF COVERAGE ENDS

The maximum period for which coverage may be continued is the end of the Plan Year in which the qualifying event occurs. However, in certain situations, the maximum duration of coverage may be 18 or 36 months from the qualifying event (depending on the type of qualifying event and the level of Non-Elective contributions provided by the Employer). You will be notified of the applicable maximum duration of Continuation of Coverage when you have a qualifying event. Regardless of the maximum period, Continuation of Coverage may end earlier for any of the following reasons:

- If the contribution for your Continuation of Coverage is not paid on time or it is significantly insufficient (Note: if your payment is insufficient by the lesser of 10% of the required premium, or $50, you will be given 30 days to cure the shortfall);

- If you become covered under another group health Plan and are not actually subject to a pre-existing condition exclusion limitation;

- If you become entitled to Medicare; or

- If the Employer no longer provides group health coverage to any of its Employees.

For additional information regarding Continuation of Coverage benefits under this Plan, please contact the Plan Administrator.

APPENDIX I

CLAIMS REVIEW PROCEDURE CHART

The *Effective Date* of this Appendix I is January 1, 2013. 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 thirty (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 thirty (30) day period. If the reason for the additional time is that you need to provide additional information, you will have forty-five (45) days from the notice of the extension to obtain that information. The time period during which Humana must make a decision will be suspended until the earlier of the date that you provide the information or the end of the forty-five (45) day period.

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

a. The reason(s) for the denial and the Plan provisions on which the denial is based;

b. A description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;

c. A description of the Plan's appeal procedures and the time limits applicable to such procedures; and

d. A right to request all documentation relevant to your claim.

Step 3: *If you disagree with the decision, file an Appeal.* If you do not agree with the decision of Humana and you wish to appeal, you must file your appeal no later than one hundred eighty (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 thirty (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 thirty (30) days after the *Plan Administrator* receives your claim. The notice will contain the same type of information that was referenced in Step 1 above.

Other important information regarding your appeals:

- Each level of appeal will be independent from the previous level (i.e., the same person(s) or subordinates of the same person(s) involved in a prior level of appeal will not be involved in the appeal);

- On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information; and

- You cannot pursue other legal remedies until you have exhausted these appeals procedures.

APPENDIX II

QUALIFYING EVENTS

The *Effective Date* of this Appendix II is January 1, 2013. It should replace and supersede any other Appendix II with an earlier date. This Plan has adopted qualifying events (i.e. election changes). See 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:

Healthcare Flexible Spending Account (HC FSA)

A. Events starting or increasing HC FSA contributions

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

2. Marriage, loss of other coverage, court or administrative orders for dependent(s) or foster child(ren), expiration of COBRA = 1st day of 1st month from the employee signature date.

3. Different open enrollment = 1st day of the 1st month (match effective date of other employer's plan).

4. Return from Leave Without Pay = 1st day of the 1st month from the employee's signature date.

5. Return from Military Leave = Date of return to work.

B. Events stopping or decreasing HC FSA contributions

1 Termination of employment = Date of termination of employment.

2. Death = Date of death.

3. Divorce, loss of dependent status = End of the month of loss of eligibility.

4. Gaining other health insurance coverage Medicare/Medicaid/Tricare/etc.) = End of the month from the employee's signature date.

5. Different open enrollment = Last day of the month (match other employer's plan).

6. Begins Leave without Pay or Military Leave = Last date of work.

APPENDIX III

ELIGIBLE CLAIMS EXPENSES

The *Effective Date* of this Appendix III is January 1, 2013. It should replace and supersede any other Appendix III with an earlier date. The Plan has established a list of eligible claim expenses to illustrate the expenses eligible under this Plan.

Note: This is only a list of examples.

***MY*HUMANA**

Visit Humana's website at www.humana.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. Go to www.humana.com and click on "Log in or Register" to receive step by step instructions on how to set up *your My*Humana page. After you have set up your page, log on at www.humana.com, anytime to check the status of your FSA account. You can also find financial tools to help with budgeting for healthcare and more.

- The urgent care center finder;
- *Your* member ID card detail information; and
- *Your* spending account balance and transaction information.

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

The *Effective Date* of this Appendix IV is January 1, 2013. It should replace and supersede any other Appendix IV with an earlier date.

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

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

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

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

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

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

Employee - means 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 or who is a retiree of a state sponsored retirement system 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.

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

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

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

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

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

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

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

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

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

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

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

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

HIPAA PRIVACY NOTICE

The *Effective Date* of this Appendix V is January 1, 2013. It should replace and supersede any other Appendix V with an earlier date.

PLAN YEAR 2013
HIPAA PRIVACY NOTICE

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

This Notice of Privacy Practices (the "Notice") describes the legal obligations of Commonwealth of Kentucky, **Personnel Cabinet, Department of Employee Insurance's Kentucky Employees' Health Plan (KEHP)** (the "Plan") and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or Healthcare operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice of Privacy Practices to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a Healthcare provider, a Healthcare clearinghouse, a health plan, 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 provision of Healthcare to you; or (3) the past, present or future payment for the provision of Healthcare to you.

If you have any questions about this Notice or about our privacy practices, please contact:
Office of Legal Services, Personnel Cabinet, 501 High Street, 3rd Floor, Frankfort, Kentucky 40601, (502) 564-7430.

Effective Date: This Notice is effective September 14, 2012.

Our Responsibilities: We are required by law to:

- Maintain the privacy of your protected health information;
- Provide you with certain rights with respect to your protected health information;
- Provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and

- Follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices by U.S. mail to your last-known address on file and your last e-mail address.

How We May Use and Disclose Your Protected Health Information: Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Payment. We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from Healthcare providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your Healthcare provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Healthcare Operations. We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities.

To Business Associates. We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate contract with us.

APPENDIX V

As Required by Law. We will disclose your protected health information when required to do so by Federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety. We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors. For the purpose of administering the plan, we may disclose to certain employees protected health information. However, those employees will only use or disclose that information as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations: In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation. If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose your protected health information for public health actions. These actions generally include the following:

- To prevent or control disease, injury, or disability;
- To report births and deaths;
- To report child abuse or neglect;

- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- To notify the appropriate government authority if we believe that an adult patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities. We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the Healthcare system, Government programs, and compliance with Civil Rights Laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may disclose your protected health information if asked to do so by a law enforcement official -

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- About a death that we believe may be the result of criminal conduct; and
- About criminal conduct.

Coroners, Medical Examiners and Funeral Directors. We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors, as necessary to carry out their duties.

National Security and Intelligence Activities. We may release your protected health information to authorized Federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with Healthcare; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research. We may disclose your protected health information to researchers when:
(1) the individual identifiers have been removed; or
(2) when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures: The following is a description of disclosures of your protected health information we are required to make.

Government Audits. We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You. When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your Healthcare benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or Healthcare operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Other Disclosures:

Personal Representatives. We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that: (1) you have been, or may be, subjected to domestic violence, abuse or neglect by such person; or (2) treating such person as your personal representative could endanger you; and (3) in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members. With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations. Other uses or disclosures of your protected health information not described above will only be made with your written authorization. You may revoke written authorization at any time, so long as the revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Your Rights: You have the following rights with respect to your protected health information:

Right to Inspect and Copy. You have the right to inspect and copy certain protected health information that may be used to make decisions about your Healthcare benefits. To inspect and copy your protected health information, you must submit your request in writing to Commonwealth of Kentucky, Personnel Cabinet, Department of Employee Insurance, ATTN: HIPAA, 501 High Street, 2nd Floor, Frankfort, KY 40601.

If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request to Commonwealth of Kentucky, Personnel Cabinet, Department of Employee Insurance, ATTN: HIPAA, 501 High Street, 2nd Floor, Frankfort, KY 40601.

Right to Amend. If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, your request must be made in writing and submitted to Commonwealth of Kentucky, Personnel Cabinet, Department of Employee Insurance, ATTN: HIPAA, 501 High Street, 2nd Floor, Frankfort, KY 40601. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Is not part of the medical information kept by or for the Plan;
- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the information that you would be permitted to inspect and copy; or
- Is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures. You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or Healthcare operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to Commonwealth of Kentucky, Personnel Cabinet, Department of Employee Insurance, ATTN: HIPAA, 501 High Street, 2nd Floor, Frankfort, KY 40601.

Your request must state a time period of not longer than six years and may not include dates before April 14, 2003.

Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or Healthcare operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had. Except as provided in the next paragraph, we are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you.

Effective February 17, 2010 (or such other date specified as the effective date under applicable law), we will comply with any restriction request if: (1) except as otherwise required by law, the disclosure is to the health plan for purposes of carrying out payment or Healthcare operations (and is not for purposes of carrying out treatment); and (2) the protected health information pertains solely to a Healthcare item or service for which the Healthcare provider involved has been paid out-of-pocket in full.

To request restrictions, you must make your request in writing to Commonwealth of Kentucky, Personnel Cabinet, Department of Employee Insurance, ATTN: HIPAA, 501 High Street, 2nd Floor, Frankfort, KY 40601. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limitations to apply— for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to Commonwealth of Kentucky, Personnel Cabinet, Department of Employee Insurance, ATTN: HIPAA, 501 High Street, 2nd Floor, Frankfort, KY 40601. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

Right to be Notified of a Breach. You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured protected health information.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our website, kehp.ky.gov.

To obtain a paper copy of this notice, you may make that request to: Commonwealth of Kentucky, Personnel Cabinet, Department of Employee Insurance, ATTN: HIPAA, 501 High Street, 2nd Floor, Frankfort, KY 40601.

Complaints: If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact Commonwealth of Kentucky, Personnel Cabinet, Department of Employee Insurance, 501 High Street, 2nd Floor, Frankfort, KY 40601. All complaints must be submitted in writing.

You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with us.

Administered by:

Humana Insurance Company
500 West Main Street
Louisville, KY 40202