# COMMONWEALTH OF KENTUCKY

# KENTUCKY EMPLOYEES HEALTH PLAN (KEHP)

# HEALTH CARE FLEXIBLE SPENDING ACCOUNT

# SUMMARY PLAN DESCRIPTION

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

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

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

Louisville Plan Number: 236117

Lexington Plan Number: 236134

Northern Kentucky Plan Number: 236215

*Effective Date*: January 1, 2009

*Plan Year*: January 1, 2009 through December 31, 2009

Employer's Federal Tax Identification Number: 61-0600439

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# PLAN INFORMATION

## GENERAL INFORMATION ABOUT THE PLAN

The Commonwealth of Kentucky (the "*Employer*") has established the Commonwealth of Kentucky Health Care Flexible Spending Account (the "*Plan*"). The *Plan* allows you to use *Pre-tax Contributions* to pay for qualified expenses. The Commonwealth of Kentucky Health Care 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 Health Care Flexible Spending Account ("Health Care FSA"). The Health Care FSA allows you to elect to use a specified amount of *Pre-tax Contributions* to be used for reimbursement of Eligible Medical Expenses. The Health Care FSA is intended to qualify as a *Code* Section 105 self-insured medical reimbursement *plan*.

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

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

## PLAN CONTACT INFORMATION

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

*Employer* / Plan Sponsor

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

*Plan Administrator*

Commonwealth of KY
Personnel Cabinet, Department of Employee Insurance
501 High Street
Second Floor
Frankfort, KY 40601
502-564-0350
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Third Party Administrator / Plan Manager

Humana
Attn: Humana Spending Account Administration Team
PO Box 14167
Lexington KY 40512-4167
Toll Free: 1-800-604-6228
Fax: 1-800-905-1851

# CAFETERIA PLAN SUMMARY

## PARTICIPATION

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

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

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

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

## ENROLLMENT

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

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

If you have satisfied the Cafeteria Plan's eligibility requirements, you 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 Health Care FSA Eligibility Requirements, you are eligible to enroll in the Commonwealth of Kentucky Health Care 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 |

# HEALTH CARE FSA ELIGIBILITY REQUIREMENTS

## PARTICIPATION

Each *employee* who satisfies the Health Care FSA Eligibility requirements is eligible to participate on the Health Care 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 Health Care FSA's Eligibility requirements, you become a *participant* in the Health Care FSA by electing Health Care Reimbursement benefits during the Initial or Annual Election Periods described in the Cafeteria Plan Summary. Your participation in the Health Care FSA will be effective on the date that you make the election or your Health Care FSA Eligibility Date, whichever is later. If you have made an election to participate and you want to participate during the next *Plan Year*, you must make an election during the Annual Election Period, even if you do not change your current election. Evergreen elections do not apply to Health Care 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 Health Care FSA, the *Employer* will establish a "Health Care Account" to keep a record of the reimbursements you are entitled to, as well as the contributions you elected to withhold for such benefits during the *Plan Year*. No actual account is established; it is merely a bookkeeping account. Benefits under the Health Care FSA are paid as needed from the *Employer*'s general assets.

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

You may elect any annual reimbursement amount subject to the maximum annual Health Care Reimbursement Amount allowed for the plan. The Maximum Annual Reimbursement Amount each year may not exceed the lesser of the Health Care FSA reimbursement amount elected for that year or $5000. There is no minimum election amount.

## HEALTH CARE FSA ELIGIBILITY REQUIREMENTS (continued)

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

Any change in your Health Care 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

To be eligible you must be a qualifying child or a qualifying relative.

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

1. A "qualifying child" (QC) of an employee under Code § 152, there are four tests: the relationship, residency, age, and limited self-support tests.

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

   - Has a specific, family-type relationship to the member taxpayer (a child of the employee or a descendant of such child; or a brother, sister, stepbrother, or stepsister of the employee or a descendant of any such relative). (The relationship test);

     - Resides with the member in his/her household for more than half of the tax year (with certain exceptions such as "temporary absences" if a full-time student). (The residency test);

     - Is under age 19 and not a full-time student (or under age 24 if a fulltime student) as of the end of the calendar year in which the member's taxable year begins. A "student" means an individual who, during each of five calendar months during the calendar year in which the employee's taxable year begins, is a full-time student at an educational organization (The age test);

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

- Individual must not provide more than half of his or her own support for the calendar year in which the taxable year of the employee begins (The limited self-support test).

2. In order to be a "qualifying relative" (QR) of an employee under Code § 152(d), there are three tests: the relationship, support, and not anyone's qualifying child tests.

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

   - Has a specific, family-type relationship to the member taxpayer (a child of the employee or a descendant of a child of the employee, a brother, sister, stepbrother, or stepsister of the employee, the father or mother of the employee, etc.) and is someone who resides with the employee in his/her household for the member's taxable year. (The relationship test);

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

   - Receives over half of his/her own support from the member-taxpayer. Support includes food, shelter, clothing, medical and dental care, education, and the like.) (The support test);

   - Is not anyone's (including the member's) "qualifying child." (See definition above) (The not anyone's qualifying child test).

NOTE: An individual generally will not be a dependent under Code § 152 if he or she is a dependent of a Code § 152 dependent, a married dependent filing a joint tax return, or a citizen or national of a country other than the United States.

## HEALTH CARE FSA ELIGIBILITY REQUIREMENTS (continued)

NOTE: 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 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.

## HEALTH CARE FSA ELIGIBILITY REQUIREMENTS (continued)

### ELECTION CHANGES

You can change your election under the Health Care 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 Health Care 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 Health Care FSA coverage ceases during an FMLA leave, you may, upon returning from FMLA leave, elect to be reinstated in the Health Care FSA at either

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

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

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

## UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

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

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

## TERMINATION OF COVERAGE

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

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

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

(iii) The date that you no longer satisfy the Health Care 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.

## HEALTH CARE FSA ELIGIBILITY REQUIREMENTS (continued)

You may be entitled to elect Continuation Coverage under the Health Care 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 Health Care FSA.

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

# HEALTH CARE FSA REIMBURSEMENT

## ELIGIBLE CLAIMS EXPENSE

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

(i) The expense is for "medical care" as defined by *Code* Section 213(d);
(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 "medical care" as any amounts incurred to diagnose, treat, or prevent a specific medical condition or for purposes of affecting any function or structure of the body. Not every health related expense you or your eligible dependents incur constitutes an expense for "medical care." For example, an expense is not for "medical care", as that term is defined by the *Code*, if it is merely for the beneficial health of you and/or your eligible dependents (e.g. vitamins or nutritional supplements that are not taken to treat a specific medical condition) or for cosmetic purposes, unless necessary to correct a deformity arising from illness, injury, or birth defect. You may, at the discretion of the Third Party Administrator/*Plan Administrator*, be asked to provide additional documentation from a health care provider showing that you have a medical condition and/or the particular item is necessary to treat a medical condition. Expenses for cosmetic purposes are also not reimbursable unless they are necessary to correct an abnormality caused by illness, injury or birth defect.

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

(i) Health insurance premiums;

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

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

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

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

## CLAIMS REIMBURSEMENT

Under this Health Care FSA, you have two reimbursement options. You can complete and submit a written claim for reimbursement (see "Traditional Paper Claims" below for more information). Alternatively, you can use an electronic payment card (see "Electronic Payment Card" below for more information) to pay the expense. In order to be eligible for the Electronic Payment Card, you must agree to abide by the terms and conditions of the Electronic Payment Card Program (the "Program") as set forth herein and in the Electronic Payment Cardholder Agreement (the "Cardholder Agreement") including 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 the Third Party Administrator. If your claim for reimbursement is approved, you will be provided reimbursement as soon as reasonably possible following the determination.

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

If it is later determined that you and/or your eligible Dependent(s) received an overpayment or a payment was made in error (e.g., you were reimbursed for an expense under the 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.

**Traditional Paper Claims**

When you incur an Eligible Medical Expense, you file a claim with the Plan's Third Party Administrator by completing and mailing or faxing a Request for Reimbursement Form. Forms can be mailed to PO Box 14167, Lexington, KY 40512-4167 or faxed to 1-800-905-1851. You may obtain a Request for Reimbursement Form from the Third Party Administrator or print a copy from the KEHP website at http://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) The date the expense was incurred; and

(iii) The amount of the expense.

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

**Electronic Payment Card**

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

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

You must agree to abide by the terms of the Program both during the Initial Election Period and during each Annual Election Period. A Cardholder Agreement will be provided to you. The Cardholder Agreement is part of the terms and conditions of your Plan and this SPD.

(b) The card will be turned off when employment or coverage terminates. The card will be turned off if you fail to provide the correct documentation to Humana, when necessary to substantiate claims. If Humana does not receive substantiation (verification) from you within thirty (30) days after you swipe the Humana Access Card, then Humana will request this substantiation from you. If substantiation is not received within 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 traditional paper claims.

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

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

(d) Health Care FSA reimbursement under the card is limited to certain providers. Use of the card for Health Care FSA expenses is limited to merchants who are providers such as doctors, and pharmacies.

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

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

(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 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 Electronic Payment Card payment matches a specific co-payment you have under the component medical plan for the particular service that was provided. For example, if you have a $10 co-pay for physician office visits, and the payment was made to a physician office in the amount of $10, you will not be required to provide the third party statement to the Claims Administrator.

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

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

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

(h) You must pay back any improperly paid claims. If you are unable to provide adequate or timely substantiation as requested by the Claims Administrator, you must repay the Plan for the unsubstantiated expense. The deadline for repaying the Plan is set forth in the Cardholder Agreement. If you do not repay the Plan within the applicable time period, the card may be turned off and an amount equal to the unsubstantiated expense will be offset against future eligible claims under the Health Care 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 payment card or the traditional paper claims approach. You have the choice as to how to submit your eligible claims. If you elect not to use the electronic payment card, you may also submit claims under the Traditional Paper Claims approach discussed above. Claims for which the Electronic Payment Card has been used cannot be submitted as Traditional Paper Claims.

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

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

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

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

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

## DENIED CLAIM

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

## UNCLAIMED HEALTH CARE REIMBURSEMENTS

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

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

# HEALTH CARE FSA CONTINUATION OF COVERAGE

## COBRA CONTINUATION OF COVERAGE

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

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

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

When Coverage May Be Continued

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

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

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

## HEALTH CARE FSA CONTINUATION OF COVERAGE (continued)

Type of Continuation Coverage

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

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

Notice Requirements

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

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

Election Procedures and Deadlines

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

## HEALTH CARE FSA CONTINUATION OF COVERAGE (continued)

Cost

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

When Continuation Coverage Ends

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

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

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

(iii) If you become entitled to Medicare; or

(iv) If the *employer* no longer provides group health coverage to any of its *employees*.

# APPENDIX I

## CLAIMS REVIEW PROCEDURE CHART

The *Effective Date* of this Appendix I is January 1, 2009. It should replace and supersede any other Appendix I with an earlier date. The Plan has established the following claims review procedure in the event you are denied a benefit under this Plan.

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

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

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

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

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

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

**Step 3:** *If you disagree with the decision, file an Appeal.* If you do not agree with the decision of the Third Party Administrator and you wish to appeal, you must file your appeal no later than 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 Third Party Administrator.* 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 the Third Party Administrator.

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

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

If the *Plan Administrator* denies your 2nd Level Appeal, you will receive notice within 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

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: Please make sure these are the HCFSA and not the HRA effective dates.

**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

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

**Assistance for the Handicapped:**

Allowable Expenses

- Cost of guide for a blind person
- Cost of note-taker for a deaf child in school
- Cost of Braille books and magazines in excess of cost of regular editions
- Seeing eye dog (cost of buying, training , and maintaining)
- Hearing-trained cat or other animal to assist deaf person (cost of buying, training, and maintaining)
- Household visual alert system for deaf person
- Excess cost of specifically equipping automobile for handicapped person over the cost of ordinary automobile; device for lifting handicapped person into automobile
- Special devices, such as tape recorder and typewriter, for a blind person

**Dental and Orthodontic Care:**

Allowable Expenses

- Dental care
- Artificial teeth/Dentures
- Cost of fluoridation of home water supply advised by dentist
- Braces, orthodontic services

Specifically Disallowed

- Teeth bleaching
- Tooth bonding that is not medically necessary

**Fees/Services:**

Allowable Expenses

- Physician's fees
- Obstetrical expenses
- Hospital services
- Nursing services for care of a specific medical ailment
- Cost of a nurse's room and board when nurse's services qualify
- The Social Security tax paid with respect to wages of a nurse when nurse's services qualify
- Surgical or diagnostic services
- Legal sterilization
- Cosmetic surgery or procedures that treat a deformity caused by an accident or trauma, disease or an abnormality at birth
- Services of chiropractors and osteopaths
- Anesthesiologist's fees
- Dermatologist's fees
- Gynecologist's fees

Specifically Disallowed

- Cosmetic surgery or procedures that improve the patient's appearance but do not meaningfully promote the proper function of the body or prevent or treat an illness or a disease
- Payments to domestic help, companion, baby-sitter, chauffeur, etc., who primarily renders services of a non-medical nature
- Nursemaids or practical nurses who render general care for healthy infants
- Fees for exercise, athletic, or health club membership, when there is no specific health reason for membership
- Payments for child care
- Marriage counseling provided by a member of the clergy

**Hearing Care:**

Allowable Expenses

- Hearing aids
- Batteries for operation of hearing aids

**Medical Equipment:**

Allowable Expenses

- Wheelchair or automate (cost of operating/maintaining)
- Crutches (purchased or rented)
- Special mattress and plywood boards prescribed to alleviate arthritis
- Oxygen equipment and oxygen used to relieve breathing problems that result from a medical condition
- Artificial limbs
- Support hose (if medically necessary)
- Wigs (where necessary for mental health or individual who loses hair because of disease)
- Excess cost of orthopedic shoes over the cost of ordinary shoes

Specifically Disallowed

- Wigs, when not medically necessary for mental health
- Vacuum cleaner purchased by an individual with dust allergy

**Miscellaneous Charges:**

Allowable Expenses

- X-rays
- Expenses of services connected with donating an organ
- Cost of computer storage of medical records
- Cost of special diet, but only if it is medically necessary and only to the extent that costs exceed that of a normal diet
- Transportation expenses primarily for, and essential to, medical care including bus, taxi, train, plane fares, ambulance services, parking fees, and tolls
- Lodging expenses (not provided in a hospital or similar institution) while away from home if all of the following requirements are met:
- Lodging is primarily for and essential to medical care.
- Medical care is provided by a doctor in a licensed hospital or in a medical care facility related to, or the equivalent of, a licensed hospital.
- Lodging is not lavish or extravagant under the circumstances.

- There is no significant element of personal pleasure, recreation, or vacation in the travel away from home. The amount included in medical expensed cannot exceed $50 for each night for each person. Lodging is included for a person for whom transportation expenses are a medical expense because that person is traveling with the person receiving medical care. For example, if a parent is traveling with a sick child, up to $100 per night is included as a medical expense for lodging (meals are not deductible).
- Amounts paid for meals during inpatient care at hospital or similar institution, if the main reason for being there is to receive medical care

Specifically Disallowed

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

## APPENDIX III (continued)

**Over the Counter (OTC) Medications:**

Allowable Expenses

**Antiseptics**

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

**Asthma Medications**

- Bronchodilator / Expectorant tablets
- Bronchial asthma inhalers

**Cold, Flu, and Allergy Medications**

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

## APPENDIX III (continued)

### Diabetes

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

### Ear / Eye Care

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

### Health Aids

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

### Pain Relief

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

**Personal Test Kits**

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

**Skin Care**

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

**Stomach Care**

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

Specifically Disallowed

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

**Physicals:**

Allowable Expenses

- Routine and preventive physicals
- School and work physicals

**Prescription Drugs:**

Allowable Expenses

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

Specifically Disallowed

- Vitamins or experimental drugs

**Psychiatric Care:**

Allowable Expenses

- Services of psychotherapists, psychiatrists, and psychologists
- Psychiatric therapy for sexual problems
- Legal fees directly related to commitment of a mentally ill person

Specifically Disallowed

- Psychoanalysis undertaken to satisfy curriculum requirements of a *student*

**Treatments and Therapies:**

Allowable Expenses

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

Specifically Disallowed

- Physical treatments unrelated to specific health problem (e.g., massage for general well-being)
- Any illegal treatment

**Vision Care:**

Allowable Expenses

- Optometrist's or ophthalmologist's fees
- Eyeglasses
- Contact lenses and cleaning solutions
- LASIK and other surgical procedures

Specifically Disallowed

- Lens replacement insurance

**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

**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.

## APPENDIX IV (continued)

**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).

## APPENDIX IV (continued)

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

# APPENDIX V

## NOTICE OF PRIVACY PRACTICES (SUMMARY)

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

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

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

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

DEI Responsibilities

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

How DEI May Use and Disclose Your Protected Health Information

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