# COMMONWEALTH OF KENTUCKY

# KENTUCKY EMPLOYEES' HEALTH PLAN (KEHP)

# LIMITED HEALTH REIMBURSEMENT ACCOUNT (WAIVER DENTAL/VISION ONLY HRA)

# SUMMARY PLAN DESCRIPTION

The Plan Sponsor has established and continues to maintain this Commonwealth of Kentucky (KEHP) Waiver Dental/Vision ONLY HRA for the benefit of its employees and their eligible *dependents* as provided in this document.

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

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

Louisville Plan Number: 239480

Lexington Plan Number: 239832

Northern Kentucky Plan Number: 240042

*Effective Date*: January 1, 2012

*Plan Year*: January 1, 2012 through December 31, 2012

Employer's Federal Tax Identification Number: 61-0600439

# TABLE OF CONTENTS

## GENERAL INFORMATION ABOUT THE PLAN

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

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

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

### GRANDFATHER CLAUSE

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

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

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

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

## PLAN CONTACT INFORMATION

If you have any questions about the Waiver Dental/Vision ONLY HRA, you should contact the Third Party Administrator or the *Plan Administrato*r.

*Employer* / Plan Sponsor

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

*Plan Administrator*

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

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

# ELIGIBILITY REQUIREMENTS

## PARTICIPATION

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

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

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

## ENROLLMENT

Once you become a Participant, the *Employer* establishes a Health Reimbursement Account for you. The Health Reimbursement Account is a notional bookkeeping account that keeps a record of Waiver Dental/Vision ONLY HRA dollars allocated to your account and reimbursements made to you under this Waiver Dental/Vision ONLY HRA. You have no property rights to the Health Reimbursement Account. Coverage under this Waiver Dental/Vision ONLY HRA for an Eligible Employee and Eligible Dependent(s) begins on January 1, 2012. In no event will the coverage under this Waiver Dental/Vision ONLY HRA begin before the *effective date* of this Waiver Dental/Vision ONLY HRA.

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

If a Medicare eligible employee is re-employed by any agency of the Commonwealth in a position working at least 100 hours per month (or otherwise eligible for benefits pursuant to KRS 18A.225), he or she will be eligible to re-enroll (or to remain enrolled) in the Kentucky Employees' Health Plan. The Waiver Dental/Vision ONLY HRA has no impact on a person's Medicare policy.

## ELECTION CHANGES

You can change your election under the Waiver Dental/Vision ONLY HRA in the following situations:

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

(ii) Following a Qualifying Event. You may change your Waiver Dental/Vision ONLY HRA election during the Plan Year only if you experience an applicable Qualifying Event.

Qualifying events are determined by your Employer and 'based on' 26 C.F.R. § 1.125-4 and Proposed Treasury Reg 1.125-2(a). Qualifying Events must be elected and signed by the employee 35 days from the date of the Qualifying Event, except for birth, adoption, or placement for adoption when adding the newly acquired dependent only, which are 60-days.

## LEAVE OF ABSENCE

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

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

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

## ELIGIBLE DEPENDENTS

Dependent means the following:

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

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

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

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

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

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

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

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

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

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

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

PLEASE NOTE:

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

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

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

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

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

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 2012, this plan is not required to extend coverage to children who are eligible for coverage under another employer's group health plan (*e.g.,* eligible under the plan of the child's own employer). This plan has interpreted this to mean the child full-time employer. A "grandfathered" plan cannot deny coverage if a child is eligible for coverage under another *parent's* group health plan, however.

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

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

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

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

## REDIRECTION OF EMPLOYER CONTRIBUTION

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

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

### 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.

## EMPLOYEE EFFECTIVE DATE OF COVERAGE

You must enroll on forms acceptable to the Plan Sponsor

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

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

## TERMINATION OF COVERAGE

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

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

## AVAILABLE FUNDS

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

The Commonwealth of Kentucky Waiver Dental/Vision ONLY HRA does not contain a Maximum Account Balance. Waiver Dental/Vision ONLY HRA dollars remaining in the Health Reimbursement Account at the end of the Plan Year will roll over to the next Plan Year, if you continue to waive health insurance coverage and you remain eligible to receive the funds. You must re-enroll each year to receive coverage.

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

## ELIGIBLE CLAIMS

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

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

Vision Dental

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

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

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

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

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

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

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

## CLAIM REIMBURSEMENT

Under this Waiver Dental/Vision ONLY HRA, you have two reimbursement options. You can complete and submit a written claim for reimbursement (see "Traditional Paper Claims" below for more information). Alternatively, you can use a Humana*Access* card (see "Electronic Payment Card" below for more information) to pay the expense. In order to be eligible for the Humana*Access* card, you must agree to abide by the terms and conditions of the Electronic Payment Card Program (the "Program") as set forth herein and in the Humana*Access* Cardholder Agreement (the "Cardholder Agreement") including limitations as to card usage, the *Plan*'s right to withhold and offset for ineligible claims, etc. The following is a summary of how both options work.

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

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

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

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

**TRADITIONAL PAPER CLAIMS**

When you incur an Eligible Medical Expense, you file a claim with Humana by completing and mailing or faxing a Request for Reimbursement Form. Forms can be mailed to PO Box 14167, Lexington, KY 40512-4167 or faxed to 1-800-905-1851. You may obtain a Request for Reimbursement Form from Humana or print a copy from the KEHP website at www.kehp.ky.gov. You must include with your Request for Reimbursement Form a written statement from an independent third party (e.g., a receipt, EOB, etc.) associated with each expense that indicates the following:

(i) The nature of the expense (e.g. what type of service or treatment was provided).

(ii) If the expense is for a prescribed over- the- counter drug, the written statement must indicate the name of the drug;

(iii) The date the expense was incurred; and

(iv) The amount of the expense.

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

**ELECTRONIC PAYMENT CARD**

The Humana*Access* card allows you to pay for Eligible Medical Expenses at the time that you incur the expense.

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

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

2. The card will be turned off when employment or coverage terminates. The card will be turned off if you fail to provide the correct documentation to Humana, when necessary to substantiate claims. If Humana does not receive substantiation (verification) from you within thirty (30) days after you swipe the Humana*Access* card, then Humana will request this substantiation from you. If substantiation is not received within 30 more days (for a total of 60 days from the initial Humana*Access* card swipe), then claims processing will be suspended. This suspension of claims will include the use of the Humana*Access* card as well as reimbursements for traditional paper claims.

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

3. As specified in the Cardholder Agreement, you certify during the applicable Election Period that the amounts in your Waiver Dental/Vision ONLY HRA will only be used for Eligible Medical Expenses (i.e. medical care expenses incurred by you, your *spouse*, and your dependents).You also certify that you have not been reimbursed for the expense and that you will not seek reimbursement for the expense from any other source. Failure to abide by this certification will result in termination of the Humana*Access* card use privileges.

4. Use of the Humana*Access* card for Waiver Dental/Vision ONLY HRA expenses is limited to merchants who are health care providers (doctors, 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 Waiver Dental/Vision ONLY HRA expenses for reimbursement using a traditional paper claim.

5. When you incur an Eligible Medical Expense at a doctor's office, such as a co-payment you swipe the Humana*Access* card at the provider's office much like you would a typical credit card. The provider is paid for the expense up to the maximum reimbursement amount available under the Waiver Dental/Vision ONLY HRA (or as otherwise limited by the Program) at the time that you swipe the Humana*Access* card. Every time you swipe the Humana*Access* card, you certify to the *Plan* that the expense for which payment under the Waiver Dental/Vision ONLY HRA is being made is an Eligible Medical Expense and that you have not been reimbursed from any other source nor will you seek reimbursement from another source.

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

   - The nature of the expense (e.g., what type of service or treatment was provided).
   - The date the expense was incurred.
   - The amount of the expense.

   You must retain this receipt for one year following the close of the *Plan year* in which the expense is incurred. Even though payment is made under the card arrangement, you may be required to submit a written third party statement (except as otherwise provided in the Cardholder Agreement). You will receive a letter from the Claims Administrator that a third party statement is needed. You must provide the third party statement to the Claims Administrator within 45 days (or such longer period provided in the letter from the Claims Administrator) of the request.

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

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

8. Pay at the provider's office with your Visa Humana*Access* Card.

   Here are the steps to take when paying for the service:

   - When you receive your service, present your primary insurance card so the provider can identify your copayment/coinsurance amount and bill your insurer.

   - Ask the provider to follow the instructions on the Humana*Access* card to submit a second claim to Humana, which takes only a few minutes.

   - Then swipe your Humana*Access* card through the credit card machine, to make the payment.

   - Select "credit" – not "debit" – for your transaction.

   - Sign and save the receipt.

9. You must pay back any improperly paid claims. If you are unable to provide adequate or timely substantiation as requested by the Claims Administrator, you must repay the *Plan* for the unsubstantiated expense. The deadline for repaying the *Plan* is set forth in the Cardholder Agreement. If you do not repay the *Plan* within the applicable time period, the Humana*Access* card will be turned off and an amount equal to the unsubstantiated expense may be offset against future eligible claims under the Waiver Dental/Vision ONLY HRA. The Plan further reserves the right to withhold the amount of any unsubstantiated expenses from your paycheck and to take any additional steps deemed necessary to properly account for any unsubstantiated expenses.

10. You can use either the Humana*Access* card or the traditional paper claims approach. You have the choice as to how to submit your eligible claims. If you elect not to use the Humana*Access* card, you may also submit claims under the Traditional Paper Claims approach discussed above. Claims for which the Humana*Access* card has been used cannot be submitted as Traditional Paper Claims.

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

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

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

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

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

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

## MAXIMUM AMOUNT OF REIMBURSEMENT

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

## DENIED CLAIMS

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

## UNCLAIMED HEALTH CARE REIMBURSEMENTS

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

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

## PRIVACY OF PROTECTED HEALTH INFORMATION

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

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

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

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

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

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

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

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

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

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

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

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

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

## COBRA CONTINUATION COVERAGE

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

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

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

When Coverage May Be Continued Under COBRA:

If you are a Participant or an Eligible Dependent under the HRA, then you may continue your coverage under the HRA if you elect COBRA continuation coverage.

Type of Coverage

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

Cost

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

# APPENDIX I

## CLAIMS REVIEW PROCEDURE CHART

The *Effective Date* of this Appendix I is January 1, 2012. It should replace and supersede any other Appendix I with an earlier date.

The *Plan* has established the following claims review procedure in the event you are denied a benefit under this *Plan*.

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

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

- The reason(s) for the denial and the *Plan* provisions on which the denial is based;
- A description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
- A description of the *Plan*'s appeal procedures and the time limits applicable to such procedures; and
- A right to request all documentation relevant to your claim

**Step 3:** If you disagree with the decision, file an Appeal. If you do not agree with the decision of the Humana and you wish to appeal, you must file your appeal no later than 180 days after receipt of the notice described in Step 1. You should submit all information identified in the notice of denial as necessary to perfect your claim and any additional information that you believe would support your claim.

**Step 4:** Notice of Denial is received from Humana. If the claim is again denied, you will be notified in writing as soon as possible but no later than 30 days after receipt of the appeal by Humana

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

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

If the *Plan Administrator* denies your 2nd Level Appeal, you will receive notice within 30 days after the *Plan Administrator* receives your claim. The notice will contain the same type of information that was referenced in Step 1 above.

Other important information regarding your appeals

- Each level of appeal will be independent from the previous level (i.e., the same person(s) or subordinates of the same person(s) involved in a prior level of appeal will not be involved in the appeal);
- On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information.
- To the extent these claims review and appeals procedures are carried out in compliance with applicable federal rules and regulations, you cannot proceed to external review or file suit in Federal Court until you have exhausted these appeals procedures.

## MISCELLANEOUS RIGHTS UNDER THE WAIVER DENTAL/VISION ONLY HRA

### Continue Group Health Plan Coverage

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

**Medicare and Medicare Secondary Payer**

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

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

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

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

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

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

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

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

# APPENDIX II

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

**Effective Dates**

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

**Waiver Dental/Vision ONLY HRA (HRA)**

A. Events allowing enrollment in a Health Plan

1 Birth, Adoption, placement for adoption = Date of the event.

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

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

4. Returning from Military Leave = Date of return to work or day after TRICARE ends (employee's option).

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

1. Termination of employment = Date of termination of employment.

2. Death = Date of death.

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

4. Start Military Leave = Date of the event.

All Qualifying Events must be signed by the employee 35 days from the date of the Qualifying Event, except for birth, adoption, or placement for adoption when adding the newly acquired dependent only, which are 60-days. Qualifying Events dealing with loss of other group coverage or gaining other group coverage may be signed by the employee prior to the Qualifying Event date. In any case, a requested change due to a Qualifying Event will not be effective prior to the event taking place.

# APPENDIX III

## ELIGIBLE CLAIMS EXPENSES

Note: This is only a list of examples.

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

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

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

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

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

**Dental and Orthodontic Care:**

Allowable Expenses

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

Specifically Disallowed

- Teeth bleaching
- Tooth bonding that is not medically necessary

**Vision Care:**

Allowable Expenses

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

Specifically Disallowed

- Lens replacement insurance

# APPENDIX IV

## DEFINITIONS

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

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

***Employer*** **-** means the Commonwealth of Kentucky and any Affiliated Employer who adopts the Plan pursuant to authorization provided by the Employer. Affiliated Employers who adopt the Plan shall be bound by the Plan as adopted and subsequently amended unless they clearly withdraw from participation herein.

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

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

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

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

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

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

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

***Summary Plan Description or "SPD"*** **-** means the Health Reimbursement Account (Waivers Only ) SPD and all appendices incorporated into and made a part of the SPD that is adopted by the Employer and as amended from time to time. The SPD and appendices are incorporated hereto by reference.

## HIPAA PRIVACY NOTICE

***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 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 health care 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 health care provider, a health care 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 health care to you; or (3) the past, present or future payment for the provision of health care to you.

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

**Effective Date:** This Notice is effective January 1, 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.

**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 health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care 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 Health Care 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.

**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 health care 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 health care; (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 health care 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 health care 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 health care 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 health care 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 health care 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 health care operations (and is not for purposes of carrying out treatment); and (2) the protected health information pertains solely to a health care item or service for which the health care 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, http://personnel.ky.gov/dei/hipaa.htm.

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.

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

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

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

## THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

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

## MICHELLE'S LAW

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

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

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

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

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

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

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

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

**The Genetic Information Nondiscrimination Act of 2008 (GINA)**

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