COMMONWEALTH OF KENTUCKY

KENTUCKY EMPLOYEES' HEALTH PLAN (KEHP)

LIMITED PURPOSE HEALTH REIMBURSEMENT ACCOUNT

(WAIVER DENTAL/VISION ONLY HRA)

SUMMARY PLAN DESCRIPTION

Louisville Plan Number: 254631

Lexington Plan Number: 254630

Northern Kentucky Plan Number: 254735

Effective Date: January 1, 2014

Plan Year: January 1, 2014 through December 31, 2014

Employer's Federal Tax Identification Number: 61-0600439

Humana

INTRODUCTION

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.

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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 healthcare expenses ("Waiver Dental/Vision ONLY HRA Eligible Healthcare 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*.

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
Toll Free: 888-581-8834
Local: 502-564-6534

PLAN ADMINISTRATOR

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

HUMANA / PLAN MANAGER

Humana
Attn: Humana Spending Account Administration
PO Box 14167
Lexington KY 40512-4167
Toll Free: 800-604-6228
Fax: 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. However, you may, 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, 2014. 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

5. Disabled Dependent - A dependent child who is totally and permanently disabled may be covered on your KEHP benefit plan beyond the end of the month in which he/she turns 26, provided the disability

   a Started before his/her 26th birthday and

   b Is medically-certified by a physician. A dependent child will be considered totally and permanently disabled if, in the judgment of KEHP, the written certification adequately demonstrates that the Dependent child is unable to engage in any substantial gainful activity by reason of medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months.

PLEASE NOTE:

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

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

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

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

The healthcare reform law (Patient Protection and Affordable Care Act) generally requires group health plans that offer dependent coverage to continue making such coverage available for an adult child until age 26.

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

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 Employer or Insurance Coordinator for details.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

Notice about your Health Insurance Protections Under the Uniformed Services Employment and Reemployment Rights Act (USERRA)

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

Health Insurance Protection

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

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

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

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 Healthcare 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 healthcare care expenses that have not been or will not be reimbursed by any other source may be Eligible Healthcare Expenses (to the extent all other conditions for Eligible Healthcare 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 Healthcare Expenses" are healthcare 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 Healthcare 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 *My*Humana.com or call 877-597-7474 to obtain a list of eligible expenses. This list is subject to change.

*MY*HUMANA

*My*Humana is personal, password-protected access on Humana's home page that provides information and tools to help covered persons make informed decisions. Go to www.humana.com and click on "Log or Register" to receive step by step instructions on how to set up your MyHumana page. After you have set up your page, log on 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 healthcare and more.

MyHumana Mobile allows you quick access to important information using your mobile device's browser. If you log in to MyHumana Mobile, using your existing MyHumana login and password, you can access:

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

"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;
- 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 Healthcare Expenses are covered both by this Waiver Dental/Vision ONLY HRA and by an *Employer* administrated FSA in which the employee participates, Eligible Healthcare 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 he Humana Access card or Paper Claims.. The Humana Access card is the preferred method to pay expenses. 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 any fees applicable to participate in the program, limitations as to card usage, the *Plan's* right to withhold and offset for ineligible claims, etc. Alternatively you can complete and submit a written claim for reimbursement (see "Paper Claims" below for more information).. 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 Healthcare 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.

ELECTRONIC PAYMENT CARD

The Humana Access card allows you to pay for Eligible Healthcare 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 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 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 Healthcare Expenses (i.e. healthcare expenses incurred by you, your *spouse*, and your dependents).You also certify that you have not been reimbursed for the expense and that you will not seek reimbursement for the expense from any other source. Failure to abide by this certification will result in termination of 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 healthcare 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 paper claim.

5. When you incur an Eligible Healthcare 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 Healthcare 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 healthcare 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.
   - The patient.

   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.

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

- **Previously Approved Claim Match**: As specified in the Cardholder Agreement, no written statement is required if the expense is the same as the amount, duration and provider as a previously approved expense. For example, the claims administrator approves a chiropractic visit. Each time the Humana Access card is swiped for subsequent visits at the same provider for the same services and same fee, a 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 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 paper claims approach. You have the choice as to how to submit your eligible claims. If you elect not to use the Humana Access card, you may also submit claims under the Paper Claims approach discussed above. Claims for which the Humana Access card has been used cannot be submitted as Paper Claims.

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 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.

PAPER CLAIMS

When you incur an Eligible Healthcare Expense, you file a claim with Humana by completing and mailing or faxing a Request for Reimbursement Form. Forms can be mailed to PO Box 14167, Lexington, KY 40512-4167 or faxed to 1-800-905-1851. You may obtain a Request for Reimbursement Form from 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 Healthcare Expenses will be made as soon as possible after receiving the claim and processing it. If the expense is determined to not be an Eligible Healthcare Expense, you will receive notification of this determination. You must submit all claims for reimbursement for Eligible Healthcare Expenses during the *Plan Year* in which they were incurred or during the Run Out Period.

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

WHEN COVERAGE MAY BE CONTINUED

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

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

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

CONTINUATION OF COVERAGE

NOTICE REQUIREMENTS

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

An Employee or Covered Dependent is responsible for notifying the Employer or Insurance Coordinator if he or she becomes covered under another group health Plan.

ELECTION PROCEDURES AND DEADLINES

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

COST

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

WHEN CONTINUATION OF COVERAGE ENDS

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

Regardless of the maximum period, Continuation of Coverage may end earlier for any of the following reasons:

- If the contribution for your Continuation of Coverage is not paid on time or it is significantly insufficient (Note: if your payment is insufficient by the lesser of 10% of the required premium, or $50, you will be given 30 days to cure the shortfall);
- If you become covered under another group health Plan and are not actually subject to a pre-existing condition exclusion limitation;
- If you become entitled to Medicare; or
- If the Employer no longer provides group health coverage to any of its Employees.

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

APPENDIX I

CLAIMS REVIEW PROCEDURE CHART

The *Effective Date* of this Appendix I is January 1, 2014. 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 healthcare 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 healthcare 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

QUALIFYING EVENTS

The *Effective Date* of this Appendix II is January 1, 2014. It should replace and supersede any other Appendix II with an earlier date.

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

The *Effective Date* of this Appendix III is January 1, 2014. It should replace and supersede any other Appendix III with an earlier date. The Plan has established a list of eligible claim expenses to illustrate the expenses eligible under this Plan.

Note: This is only a list of examples.

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

*My*Humana is personal, password-protected access on Humana's home page that provides information and tools to help covered persons make informed decisions. Go to www.humana.com and click on "Log or Register" to receive step by step instructions on how to set up your MyHumana page. After you have set up your page, log on 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 healthcare and more.

MyHumana Mobile allows you quick access to important information using your mobile device's browser. If you log in to MyHumana Mobile, using your existing MyHumana login and password, you can access:

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

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

The Effective Date of this Appendix IV is January 1, 2014. It should replace and supersede any other Appendix IV with an earlier date.

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.

APPENDIX V

HIPAA PRIVACY NOTICE

The Effective Date of this Appendix V is January 1, 2014. It should replace and supersede any other Appendix V with an earlier date.

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

PLEASE REVIEW IT CAREFULLY!

Effective August 1, 2013

This Notice of Privacy Practices (the "Notice") describes the legal obligations of the Kentucky Employees' Health Plan ("KEHP" or "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") and subsequent regulations. 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.

If you have any questions about this Notice or about our privacy practices, please contact: Sharron S. Burton, Deputy Executive Director and Privacy Officer, Office of Legal Services, Personnel Cabinet, 501 High Street, 3rd Floor, Frankfort, Kentucky 40601; Phone: (502) 564-7430; Fax: (502) 564-7603; E-mail: Sharron.Burton@ky.gov.

KEHP Responsibilities

We are required by law to:

- Maintain the privacy of 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;
- Notify affected individuals following a breach of unsecured protected health information; and
- Abide by 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 notice provisions effective 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 post the change or the revised Notice on the Personnel Cabinet, Department of Employee Insurance website at www.kehp.ky.gov. In addition, notice regarding our privacy practices will be included in the annual open enrollment materials.

What is Protected Health Information?

The HIPAA Privacy Rule protects only certain medical information known as protected health information. **Protected Health Information or PHI** is individually identifiable health information that is transmitted or maintained in electronic media or in any other form or medium. PHI does not include employment records held by an employer acting in their role of employer.

Individually identifiable health information is health information about you, including demographic information such as your name, address, telephone number, or Social Security number. It also includes information that is created or received by a health care provider, a health plan, and employer that relates to your physical or mental health or condition, the provision of health care to you, or the payment of your healthcare.

Permitted Use and Disclosures

Under the law, we may use or disclose your PHI under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your PHI. For each category of uses and disclosures, we will explain what we mean and provide 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 listed categories.

We have the right to use and disclose your PHI:

- **To You or Your Personal Representative** including corresponding with you about your plan and benefits available to you;
- Pursuant to and in compliance with a **Valid Authorization** or an **Agreement** with you;
- **For Treatment**, including the provision, coordination, or management of health care and related services;
- **For Payment**, including activities to collect premiums, to fulfill responsibility for coverage and provide benefits under the health plan, to obtain or provide reimbursement for the provision of health care, to determine eligibility or coverage, to process claims, to adjudicate or subrogate claims, to pay for the treatment and services you receive from health care providers, to carry out collection activities, and to perform utilization review activities such as preauthorization;

- **For Health Care Operations** including conducting quality assessment and improvement, engaging in activities to improve health or reduce health care costs, conducting case management and care coordination, contacting doctors and patients with information about treatment alternatives, reviewing the competence or qualifications of and credentialing health care providers, enrollment activities, premium rating, arranging for medical review and auditing functions, arranging for legal review, fraud and abuse detection programs, resolving internal grievances, providing customer service, business planning and development, and for general Plan administration activities;

- **Incident** to a use or disclosure otherwise permitted by HIPAA;

- **To Business Associates** that create, receive, maintain, or transmit PHI on behalf of KEHP. A Business Associate may provide legal, actuarial, accounting, consulting, data aggregation, management, and administrative services for KEHP. A Business Associate may only disclose your information as permitted or required by its contract with KEHP or as required by law;

- **To Plan Sponsors** including employees who require PHI for the administration of the Plan. These employees will only use or disclose that information necessary to perform Plan administration functions, such as enrollment and termination, or as otherwise required by HIPAA, unless you have authorized further disclosures;

- **An Employer** about an individual who is a member of the workforce of the employer if the PHI that is disclosed consists of findings concerning a work-related illness or injury or a workplace-related medical surveillance; and

- **As Required by Federal, State, or Local Law** and the use or disclosure complies with and is limited to the relevant requirements of such law.

To the extent required and permitted by law, when using or disclosing PHI, KEHP will make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.

Limited Uses and Disclosures:

We may, with certain limitations specified by HIPAA, use and disclose PHI about you:

- **To a Family Member, Relative, Close Personal Friend, Personal Representative or Any Other Person identified by you** provided the disclosure is directly relevant to such persons' involvement with your health care or payment related to your health care;

- **To Notify** or assist in the notification of a family member, your personal representative, or another person responsible for your care regarding your location, general condition, or death;

- **To a Public or Private Entity** authorized by law or by its charter to assist in disaster relief efforts;

- **As Required by Federal, State, or Local Law** and the use or disclosure complies with and is limited to the relevant requirements of such law;

- **For Public Health Activities** including disclosure to a public health authority that is authorized by law to collect or receive PHI for the purpose of preventing or controlling disease, injury, or disability which includes reporting of disease, injury, or vital events such as birth or death, and the conduct of public health surveillance, public health investigations, and public health interventions; to report child abuse or neglect; to collect or report on the quality, safety, or effectiveness of products or activities; to enable product recalls, repairs, or replacements; to notify a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition;

- **To your Employer** if you receive health care at the request of your employer for the evaluation relating to medical surveillance of the workplace or to evaluate whether you have had a work-related illness or injury;

- **To a School** if you are a student or a prospective student of the school and the PHI that is disclosed is limited to proof of immunization, the school is required to have such proof, and you or a personal representative agree to the disclosure;

- **To a Government Authority** if we reasonably believe that you are a victim of abuse, neglect, or domestic violence to the extent the disclosure is required by law, you agree to the disclosure, or the disclosure is expressly authorized by law and we believe the disclosure is necessary to prevent serious harm to you or other potential victims, or you are unable to agree because of incapacity;

- **To a Health Oversight Agency** for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; or other activities necessary for appropriate oversight of the health care system, government benefit programs, government regulatory programs, and determining compliance with civil rights laws;

- **In the Course of any Judicial or Administrative Proceeding** and in response to an order of a court or administrative tribunal, a subpoena, a discovery request, or other lawful process;

- **To Law Enforcement** including instances where you are suspected to be a victim of a crime, or for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person;

- **To a Coroner or Medical Examiner** for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law;

- **To a Funeral Director** as necessary to carry out their duties with respect to the decedent;

- **To Organ Procurement Organizations** or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue and for the purpose of facilitating organ, eye, or tissue donation or transplantation;

- **For Research Purposes** when the individual identifiers have been removed or 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;

- **To Avert a Serious Threat to Health or Safety** and the disclosure is to persons reasonably able to prevent or lessen the threat or is necessary for law enforcement authorities to identify or apprehend an individual;

- **For Military and Veterans Activities or to Federal Officials** for purposes including to assure the proper execution of a military mission, conducting lawful intelligence and counter-intelligence, conducting national security activities, and providing protective services to the President;

- **To Correctional Institutions and other Law Enforcement Custodians** about inmates;

- **To Government Agencies Administering a Government Program** providing public benefits if the sharing of eligibility or enrollment information among such government agencies or the maintenance of such information in a single or combined data system accessible to all such government agencies is required or expressly authorized by statute or regulation;

- **For Workers' Compensation** compliance purposes or other similar programs that provide benefits for work-related injuries or illness without regard to fault; and

- **To Raise Funds** provided the use or disclosure is to a Business Associate or an institutionally-related foundation and the information used or disclosed is limited to that permitted by HIPAA. You have a right to opt out of receiving fundraising communications. See, the "Your Rights Under HIPAA" section of this Notice.

Required Uses and Disclosures:

We are required to disclose your PHI:

- **To You** upon request;

- **To Your Personal Representative** unless we have a reasonable belief that you may be subjected to domestic violence, abuse, or neglect or treating such person as the personal representative could endanger you, or we decide that it is not in the best interest of the individual to treat the person as your personal representative. We will require written notice/authorization and supporting documentation proving that an individual has been designated as your personal representative; and

- **To the Secretary** of the U.S. Department of Health & Human Services as directed when required to investigate or determine the Plan's compliance with HIPAA.

Prohibited Uses and Disclosures:

We are prohibited from:

- Using or disclosing **Genetic Information** for underwriting purposes;

- Using or disclosing PHI in violation of a **Restriction** to which KEHP has agreed except where emergency treatment is needed;

- Except as indicated in the Permitted, Limited, and Required Uses and Disclosures sections of this Notice, using or disclosing PHI without a **Valid Authorization** including the use and disclosure of psychotherapy notes, the use and disclosure of information for marketing purposes, and the sale of PHI; and

- Disclosing PHI to a Plan sponsor for the purpose of **Employment-Related Actions or Decisions** or in connection with any other benefit or employee benefit plan of the Plan sponsor.

Uses and Disclosures that Require Authorization:

Except as otherwise described in this Notice, we may not use or disclose PHI without a valid authorization.

A valid authorization is specifically required:

- For any use or disclosure of **Psychotherapy Notes**, except to carry out treatment, payment, or health care operations or to defend KEHP in a legal action or other proceeding brought by you;

- For any use or disclosure of PHI for **Marketing** except if the communication is in the form of a face-to-face communication with you or a promotional gift of nominal value is provided. "Marketing" does not include communications made to describe a health-related product or service that is provided by, or included in the plan of benefits of KEHP; and

- For any disclosure of protected health information which is a **Sale** of such information.

Uses and disclosures of PHI that are not described in this Notice will be made only with the individual's written valid authorization.

A valid authorization must be written in plain language and include specific information. For your convenience, and to ensure that your authorization is valid and contains all required information, you may submit your authorization on KEHP's "Authorization for Release of Your Protected Health Information" form. The form may be obtained by contacting the Privacy Officer or by accessing KEHP's Web site at www.kehp.ky.gov.

You may revoke an authorization previously given at any time provided the revocation is in writing and:

- Except to the extent that KEHP has taken action in reliance on the authorization; or

- If the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Your Rights under HIPAA

You have the right to:

- **Request Restrictions** on certain uses and disclosures of PHI to carry out treatment, payment, or health care operations. You may also request restrictions on uses and disclosures of your PHI to family members, relatives, close personal friends, or other persons identified by you who are involved in your health care or payment for that care. We are not required to agree to your requested restriction except:

    - When the disclosure is for the purpose of carrying out payment or health care operations;

    - The disclosure is not otherwise required by law; and

    - The PHI pertains solely to a health care item or service for which the individual, or person other than the health plan on behalf of the individual, has paid in full.

Your request for a restriction must be made in writing and:

- Identify the information you want to restrict;
- State whether you want to limit our use, disclosure, or both; and
- Identify the persons to whom you want the restriction to apply (i.e. your spouse).

If we agree to a requested restriction on certain uses and disclosures, we will not use or disclose PHI in violation of such restriction, except where the restricted information is needed to provide emergency treatment.

For your convenience, and to ensure that your request contains all necessary information, you may submit your request on KEHP's "Request for Restriction on Use and Disclosure of Your Protected Health Information" form. The form may be obtained by contacting the Privacy Officer or by accessing KEHP's Web site at www.kehp.ky.gov;

- **Receive Confidential Communications.** You may request to receive communications of PHI by alternative means or at alternative locations (i.e. at home, at work). Your request must be made in writing.

We will accommodate all reasonable requests provided:

- You state that the disclosure of all or part of your PHI could endanger you;
- You specify how payment, if any, will be handled; and
- You provide an alternate address or other method of contact.

For your convenience, and to ensure that your request contains all necessary information, you may submit your request on KEHP's "Request for Alternative Communications Regarding Your Protected Health Information" form. The form may be obtained by contacting the Privacy Officer or by accessing KEHP's Web site at www.kehp.ky.gov;

- **Inspect and Copy** your PHI in a designated record set except for:
  - Psychotherapy notes;
  - Information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding;
  - PHI that is subject to or exempt from the Clinical Laboratory Improvements Amendments of 1988;
  - PHI not maintained in a designated record set;

- If access is temporarily suspended because research is in progress, provided you have agreed to the denial of access when consenting to participate in the research;

- If denial of access under the Privacy Act would meet the requirements of that law; and

- If your information was obtained from someone other than a health care provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information.

Your request for access to or a copy of your PHI must be made in writing and is subject to a reasonable, cost-based fee.

You have a right to a review of certain denials of access to your PHI by a licensed health care professional who was not directly involved in the denial.

For your convenience, and to ensure that your request contains all necessary information, you may submit your request on KEHP's "Request to Inspect or Copy Your Protected Health Information" form. The form may be obtained by contacting the Privacy Officer or by accessing KEHP's Web site at www.kehp.ky.gov;

- **Amend** your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set. We may deny your request for amendment if we determine that the PHI or record that is the subject of the request:

    - Was not created by us, unless you provide a reasonable basis to believe that the originator of the PHI is no longer available to act on the requested amendment;

    - Is not part of the information that you would be permitted to inspect and copy;

    - Would not be available for inspection due to an exception; or

    - Is accurate and complete.

Your request for a restriction must be made in writing and include a reason to support the requested amendment.

You have a right to submit a written statement disagreeing with a denial to amend. If you do not submit a statement of disagreement, you may request that we provide your request for amendment and the denial with any future disclosures of the PHI that is the subject of the amendment.

For your convenience, and to ensure that your request contains all necessary information, you may submit your request on KEHP's "Request to Amend Your Protected Health Information" form. The form may be obtained by contacting the Privacy Officer or by accessing KEHP's Web site at www.kehp.ky.gov;

- **Receive an Accounting of Disclosures** of PHI made by us in the six years prior to the date on which the accounting is requested, except for uses and disclosures:
    - To carry out treatment, payment, and health care operations;
    - Made to you about your PHI;
    - Incident to a use or disclosure otherwise permitted or required by HIPAA;
    - Made pursuant to an authorization;
    - To persons involved in your care or other permitted notifications;
    - For national security or intelligence purposes;
    - To correctional institutions or law enforcement officials; or
    - Temporarily suspended by a health oversight agency or law enforcement official.

  Your request for an accounting of disclosures must be made in writing and:
    - State in what form you want the list (i.e. paper, electronic);
    - State a time period of not longer than six years prior to the date of your request; and
    - Is subject to a reasonable, cost-based fee.

For your convenience, and to ensure that your request contains all necessary information, you may submit your request on KEHP's "Request for Accounting of Disclosures of Your Protected Health Information" form. The form may be obtained by contacting the Privacy Officer or by accessing KEHP's Web site at www.kehp.ky.gov;

- **Receive a Paper Copy of this Notice** at any time upon request. Your request must be made in writing and submitted to the Privacy Officer. The Notice may be viewed at our Web site, www.kehp.ky.gov;

- **Be Notified of a Breach of Unsecured Protected Health Information**. Following the discovery of a breach of unsecured PHI we will notify you if your information has been or we reasonably believe your information has been accessed, acquired, used, or disclosed as a result of such breach; and

- **Complain** to us and to the Secretary of the U.S. Department of Health and Human Services ("HHS") if you believe your privacy rights have been violated. Your complaint must:

  - Be in writing;
  - Name the person that is the subject of the complaint;
  - Describe the acts or omissions believed to be in violation of HIPAA; and
  - Be filed within 180 days of when the complainant knew or should have known that the act or omission complained of occurred, unless this time limit is waived by the Secretary of HHS for good cause shown.

  You will not be penalized or retaliated against for filing a complaint with us or with the Secretary.

All written requests and complaints must be submitted to:

ATTN: HIPAA Privacy Officer
Commonwealth of Kentucky
Personnel Cabinet
Department of Employee Insurance
502 High Street, 3rd Floor
Frankfort, KY 40601

If you are submitting a complaint to the Secretary of HHS, you should follow the complaint filing instructions on the HHS website at www.hhs.gov.

ADDITIONAL NOTICES

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).

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).

Administered by:

Humana

Humana Insurance Company
500 West Main Street
Louisville, KY 40202