HUMANA.
Guidance when you need it most

COMMONWEALTH OF KENTUCKY

KENTUCKY EMPLOYEES' HEALTH PLAN (KEHP)

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

SUMMARY PLAN DESCRIPTION

Louisville Plan Number: 236118

Lexington Plan Number: 236135

North Kentucky Plan Number: 236216

Effective Date: January 1, 2013

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

Employer's Federal Tax Identification Number: 61-0600439

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INTRODUCTION

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

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

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

PLAN INFORMATION

GENERAL INFORMATION ABOUT THE PLAN

The Commonwealth of Kentucky (the "*Employer*") has established the Commonwealth of Kentucky Dependent Care Flexible Spending Account (the "Plan"). The Plan allows you to use *Pre-tax Contributions* to pay for qualified expenses. This Plan helps you because the benefits you elect are nontaxable. The Commonwealth of Kentucky Dependent Care Flexible Spending Account contains two components:

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

(ii) The Dependent Care Spending Account ("Dependent Care FSA"). The Dependent Care FSA allows you to elect to use a specified amount of *Pre-tax Contributions* to be used for reimbursement of Employment Related Expenses. The Dependent Care FSA is intended to qualify as a *Code* Section 129 dependent care assistance plan.

Each of these components is summarized in this document. Each summary and the attached Appendices constitute the *Summary Plan Description* for the Commonwealth of Kentucky Dependent Care Flexible Spending Account. The *SPD* (collectively, the *Summary Plan Description* or "*SPD*") describes the basic features of the Plan(s), how they operate, and how you can get the maximum advantage from them. Certain words in this Summary are italicized. Italicized words reflect important terms that are specifically defined in Appendix III of this Summary. You should pay special attention to these terms as they play an important role in defining your rights and responsibilities under the Plan(s).

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

PLAN CONTACT INFORMATION

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

Employer / Plan Sponsor

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

Plan Administrator

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

Third Party Administrator

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

PARTICIPATION

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

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

Eligibility for coverage under any given Benefit Plan Option shall be determined not by this Plan but by the terms of that Benefit Plan Option. The terms of eligibility of this Cafeteria Plan do not override the terms of eligibility of each of the Benefit Plan Options. In other words, if you are eligible to participate in this Cafeteria Plan, it does not necessarily mean you are eligible to participate in the Benefit Plan Options. See KRS 18A.225 and KRS 18A.227.

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

ENROLLMENT

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

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

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

The Cafeteria Plan has three election periods:

(i) The "Initial Election Period," (Upon Hire)
(ii) The "Annual Election Period," (Open Enrollment) and
(iii) The "Election Change Period", which is the period following the date you have a *Qualifying Event*.

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

THE INITIAL ELECTION PERIOD

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

THE ANNUAL ELECTION PERIOD

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

ELECTION CHANGES

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

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

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

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

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

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

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

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

LEAVE OF ABSENCE

The following is a general summary of the rules regarding participation in the Cafeteria Plan (and the Benefit Plan Options) during a leave of absence. The specific election changes that you can make under this Cafeteria Plan following a leave of absence are described in the Qualifying Event Chart following a leave of absence are:

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

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

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

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

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

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

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

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

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

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

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

TERMINATION OF COVERAGE

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

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

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

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

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

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

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

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

TRANSFERS

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

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

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

TAX ADVANTAGES

You save both Federal income tax and FICA (Social Security) taxes by participating in the Cafeteria Plan. Cafeteria Plan participation will reduce the amount of your taxable *compensation*. Accordingly, there could be a decrease in your Social Security benefits and/or other benefits (e.g., pension, disability, and life insurance) that are based on taxable *compensation*.

DEPENDENT CARE ELIGIBILITY REQUIREMENTS

PARTICIPATION

Each *employee* who satisfies the Dependent Care FSA Eligibility Requirements is eligible to participate in the Dependent Care FSA on the Dependent Care FSA Eligibility Date.

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

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

You may also become a *participant* if you experience a *Qualifying Event* that permits you to enroll mid-year.

ENROLLMENT

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

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

The annual amount cannot exceed the maximum Dependent Care Reimbursement amount specified in Section 129 of the Internal Revenue *Code*. There is no minimum contribution amount. The maximum annual amount if you are –

Married and file a joint return	$5,000 per *Plan Year*
Married but your *Spouse* maintains a separate residence for the last 6 months of the calendar year, you file a separate tax return, and you furnish more than one-half the cost of maintaining those Dependents for whom you are eligible to receive tax-free reimbursements under the Dependent Care FSA	$2,500 per *Plan Year*
Single head of household	$5,000 per *Plan Year*

If you are married and reside together, but file a separate Federal income tax return, the maximum Dependent Care Reimbursement that you may elect is $2,500. In addition, the amount of reimbursement that you receive on a tax free basis during the *Plan Year* cannot exceed the lesser of your earned income (as defined in *Code* Section 32) or your *spouse*'s earned income.

Your *Spouse* will be deemed to have earned income of $250 if you have one Qualifying Individual and $500 if you have two or more Qualifying Individuals (described below), for each month in which your *Spouse* is

(i) Physically or mentally incapable of caring for himself or herself, or
(ii) A full-time *student* (as defined by *Code* Section 21).

TAX ADVANTAGES

You will not normally be taxed on your Dependent Care Reimbursement so long as your family's aggregate Dependent Care Reimbursement (under this Dependent Care FSA) does not exceed the maximum annual reimbursement limits described above. However, to qualify for tax-free treatment, you will be required to list the names and taxpayer identification numbers on your annual tax return of any persons who provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement.

You may not claim any other tax benefit for the tax-free amounts received by you under this Dependent Care FSA, although the balance of your Eligible Employment Related Expenses may be eligible for the dependent care credit.

The household and dependent care credit is an allowance for a percentage of your annual, Eligible Employment Related Expenses as a credit against your Federal income tax liability under the U.S. Tax *Code*. In determining what the tax credit would be, you may take into account only $3,000 of such expenses for one Qualifying Individual, or $6,000 for two or more Qualifying Individuals. Depending on your adjusted gross income, the percentage could be as much as 35% of your Eligible Employment Related Expenses (to a maximum credit amount of $1,050 for one Qualifying Individual or $2,100 for two or more Qualifying Individuals,) to a minimum of 20% of such expenses. The maximum 35% rate must be reduced by 1% (but not below 20%) for each $2,000 portion (or any fraction of $2,000) of your adjusted gross income over $15,000.

Illustration: Assume you have one Qualifying Individual for whom you have incurred Eligible Employment Related Expenses of $3,600, and that your adjusted gross income is $21,000. Since only one Qualifying Individual is involved, the credit will be calculated by applying the appropriate percentage to the first $3,000 of the expenses. The percentage is, in turn, arrived at by subtracting one percentage point from 35% for each $2,000 of your adjusted gross income over $15,000. The calculation is: 35% -- [($21,000 - 15,000)/$2,000 X 1%] = 32%. Thus, your tax credit would be $3,000 X 32% = $960. If you had incurred the same expenses for two or more Qualifying Individuals, your credit would have been $3,600 X 32% = $1,152, because the entire expense would have been taken into account, not just the first $3,000.

ELECTION CHANGES

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

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

(ii) Following a *Qualifying Event*. You may change your Dependent Care FSA election <u>during</u> the *Plan Year* only if you experience a *Qualifying Event*.

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

LEAVE OF ABSENCE

Refer to the Cafeteria Plan Summary or contact your Employer or Insurance Coordinator to determine what, if any, specific changes you can make during a leave of absence.

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.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

CONTINUATION OF BENEFITS

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

ELIGIBILITY

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

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

PREMIUM PAYMENT

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

DURATION OF COVERAGE

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

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

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

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

OTHER INFORMATION

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

TERMINATION OF COVERAGE

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

Your coverage under the Dependent Care FSA ends on the earlier of the following to occur:

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

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

The date that you no longer satisfy the Dependent Care FSA Eligibility Requirements;

The date that you terminate employment; or

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

If you terminate employment or you cease to be eligible during the *Plan Year*, you may submit for reimbursement Eligible Employment Related Expenses incurred prior to your termination date up to the amount of your Dependent Care Account.

ELIGIBLE CLAIMS EXPENSE

Eligible Expenses must be incurred ***during*** the *Plan Year*. You may not be reimbursed for any expenses arising before the Dependent Care FSA becomes effective or for any expenses incurred after the termination date.

You may be reimbursed for dependent care expenses ("Eligible Expenses"). Generally, an expense must meet all of the following conditions for it to be an Eligible Expense:

1. The expense is incurred for services rendered after the date of your election to receive Dependent Care Reimbursement benefits and during the calendar year to which it applies.

2. Each individual for whom you incur the expense is a "Qualifying Individual." A Qualifying Individual is:

   (i) An individual age 12 or under who

      (a) Has the same principal place of abode as you,

      (b) Does not provide over half of his/her own support and

      (c) Is your “child” (son, daughter, grandchildren, step children, brother, sister, niece and nephew).

   Note: There is a special rule for children of divorced parents. If you are divorced, the child is a qualifying individual with respect to you if the child lives with you even if you have permitted the non-custodial parent to take the exemption; or

   (ii) A *Spouse* or other Dependent (as defined in *Code* Section 152) who is physically or mentally incapable of caring for himself or herself and who has the same principal place of abode as you for more than half of the year. NOTE: Effective January 1, 2005, there is an income limitation, in addition to a support requirement (and a residence requirement for certain non-relatives) for all individuals (other than a *Spouse*) age 19 and older (or between age 19 and 26) under *Code* Section 152. Generally, such an individual cannot qualify as a *Code* Section 152 Dependent if he/she has gross income in excess of the exemption amount under *Code* Section 151.

3. The expense is incurred for the care of a Qualifying Individual (as described above), or for related household services, and is incurred to enable you (and your *Spouse*, if applicable) to be gainfully employed. Expenses for overnight stays or overnight camp are not eligible. Tuition expenses for kindergarten (or above) do not qualify.

4. If the expense is incurred for services outside your household and such expenses are incurred for the care of a Qualifying Individual who is age 13 or older, such Dependent regularly spends at least 8 hours per day in your home.

   If the expense is incurred for services provided by a dependent care center (i.e., a facility that provides care for more than 6 individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.

   The expense is not paid or payable to a "child" (as defined in *Code* Section 152(f)(1)) of yours who is under age 19 the entire year in which the expense is incurred or an individual for whom you or your *Spouse* is entitled to a personal tax exemption as a Dependent.

6. You must supply the taxpayer identification number for each dependent care service provider to the IRS with your annual tax return by completing IRS Form 2441.

   You are encouraged to consult your personal tax advisor or IRS Publication 17 "Your Federal Income Tax" for further guidance as to what is or is not an Eligible Expense if you have any doubts. In order to exclude from income the amounts you receive as reimbursement for dependent care expenses, you are generally required to provide the name, address and taxpayer identification number of the dependent care service provider on your Federal income tax return.

"Qualifying Dependent Care Services" means the following: Services that both (1) relate to the care of a Qualifying Individual that enable the Participant and his or her Spouse to remain gainfully employed after the date of participation in the DAP Component and during the Period of Coverage; and (2) are performed— in the Participant's home; or outside the Participant's home for (1) the care of a Participant's qualifying child who is under age 13; or (2) the care of any other Qualifying Individual who regularly spends at least eight hours per day in the Participant's household. In addition, if the expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than six individuals not residing at the facility and that receives a fee, payment, or grant for such services), then the center must comply with all applicable state and local laws and regulations.

CLAIMS REIMBURSEMENT

Under this Dependent Care FSA, you can complete and submit a written claim for reimbursement.

Traditional Paper Claims

When you incur an Eligible Expense, you file a claim with Humana by completing and submitting 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 atkehp.ky.gov. You must include with your Request for Reimbursement Form a written statement from an independent third party (e.g., a bill from the day care provider.) associated with each expense that indicates the following:

(i) The nature of the expense;
(ii) The date the expense was incurred; and
(iii) The amount of the expense.

Humana will process the claim once it receives the Request for Reimbursement Form from you. You must submit all claims for reimbursement for Eligible Expenses during the *Plan Year* in which they were incurred or during the Run Out Period.

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

If it is later determined that you received an overpayment or a payment was made in error you will be required to refund the overpayment or erroneous reimbursement.

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 Dependent Care FSA.

DENIED CLAIM

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

UNCLAIMED DEPENDENT CARE REIMBURSEMENTS

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

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Eligible Expenses you have incurred and the annual Dependent Care Reimbursement you have elected and paid for. Any amount credited to a Dependent Care Account shall be forfeited by the *Participant* and restored to the *Employer* if it has not been applied to provide the elected reimbursement for any *Plan Year* by the end of the Run Out Period following the end of the *Plan Year* for which the election was effective. Amounts so forfeited shall be used to offset reasonable administrative expenses and future costs or as otherwise permitted under applicable law.

APPENDIX I

CLAIMS REVIEW PROCEDURE CHART

The *Effective Date* of this Appendix I is January 1, 2013. It should replace and supersede any other Appendix I with an earlier date. The Plan has established the following claims review procedure in the event you are denied a benefit under this Plan.

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

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

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

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

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

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

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

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

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

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

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

APPENDIX II

The *Effective Date* of this Appendix II is January 1, 2013. It should replace and supersede any other Appendix II with an earlier date. This Plan has adopted qualifying events (i.e. election changes). See 26 C.F.R § 1-125-4 and Prop. Treas. Reg. § 1.125-2(a)(1). Please contact your employer or insurance coordinator for additional information concerning this Plan's qualifying events.

Effective Dates

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

Dependent Care Flexible Spending Account (DC FSA)

A Events starting or increasing DC FSA contributions

1. Dependent is newly eligible to begin attending day care = 1st day of 1st month from the employee's signature date.

2 Change in dependent's eligibility status = 1st day of 1st month from the employee's signature date.

B. Events stopping or decreasing DC FSA contributions

1 Termination of employment = Date of termination of employment.

2 Dependent no longer attends day care = End of the month from the employee's signature date.

3 Change in dependent's eligibility status = End of the month from the employee's signature date.

4. Death = Date of death.

All Qualifying Events must be signed by the employee thirty-five (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 sixty (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

DEFINITIONS

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

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

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

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

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

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

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

Employee - means a person who is employed by a Participating Agency with the Kentucky Employees' Health Plan and is eligible to apply for coverage under the Kentucky Employees' Health Plan or who is a retiree of a state sponsored retirement system health plan. See KRS 18.225 and KRS 18.227.

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

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

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

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

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

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

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

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

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

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

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

APPENDIX IV

HIPAA PRIVACY NOTICE

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

PLAN YEAR 2013
HIPAA PRIVACY NOTICE

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

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

We are required to provide this Notice of Privacy Practices to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a healthcare provider, a healthcare clearinghouse, a health plan, or your employer on behalf of a group health plan, that relates to: (1) your past, present or future physical or mental health or condition; (2) the provision of healthcare to you; or (3) the past, present or future payment for the provision of healthcare to you.

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

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

Our Responsibilities: We are required by law to:

- Maintain the privacy of your protected health information;
- Provide you with certain rights with respect to your protected health information;
- Provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- Follow the terms of the Notice that is currently in effect.

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

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

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

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

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

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.

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

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

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

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

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

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

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

- To prevent or control disease, injury, or disability;
- To report births and deaths;
- To report child abuse or neglect;
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;

- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;

- To notify the appropriate government authority if we believe that an adult patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

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

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

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

- In response to a court order, subpoena, warrant, summons or similar process;

- To identify or locate a suspect, fugitive, material witness, or missing person;

- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;

- About a death that we believe may be the result of criminal conduct; and

- About criminal conduct.

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

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

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

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

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

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

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

Other Disclosures:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Research. We may disclose your protected health information to researchers when;

(1) The individual identifiers have been removed; or
(2) When an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information, and approves the research.

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

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

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

Other Disclosures:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you.

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

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

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

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

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

Administered by:

Humana Insurance Company
500 West Main Street
Louisville, KY 40202