



Humana

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, 2014

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

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 INFORMATION (continued)

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
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888-581-8834
502-564-6534

PLAN ADMINISTRATOR

Commonwealth of Kentucky
Personnel Cabinet, Department of Employee Insurance
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HUMANA / PLAN MANAGER

Humana
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PO Box 14167
Lexington, KY 40512-4167
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CAFETERIA PLAN SUMMARY

PARTICIPATION

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

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.

CAFETERIA PLAN SUMMARY (continued)

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

CAFETERIA PLAN SUMMARY (continued)

- (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 *Participants* while they are on paid leave (provided *Participants* 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*.

CAFETERIA PLAN SUMMARY (continued)

- (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 *Participants*. Alternatively, the *Employer* may require all *Participants* 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 *Participants* 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.

CAFETERIA PLAN SUMMARY (continued)

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.

CAFETERIA PLAN SUMMARY (continued)

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 –

DEPENDENT CARE ELIGIBILITY REQUIREMENTS (continued)

Married and file a joint return	\$5,000 per <i>Plan Year</i>
Married but your <i>Spouse</i> 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 <i>Plan Year</i>
Single head of household	\$5,000 per <i>Plan Year</i>

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.

DEPENDENT CARE ELIGIBILITY REQUIREMENTS (continued)

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: $35\% - [(\$21,000 - 15,000)/\$2,000 \times 1\%] = 32\%$. Thus, your tax credit would be $\$3,000 \times 32\% = \960 . If you had incurred the same expenses for two or more Qualifying Individuals, your credit would have been $\$3,600 \times 32\% = \$1,152$, 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 during 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.

DEPENDENT CARE ELIGIBILITY REQUIREMENTS (continued)

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*.

DEPENDENT CARE ELIGIBILITY REQUIREMENTS (continued)

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.

DEPENDENT CARE REIMBURSEMENT

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.

DEPENDENT CARE REIMBURSEMENT (continued)

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.

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 at kehpnky.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.

DEPENDENT CARE REIMBURSEMENT (continued)

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, 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 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.

APPENDIX I (continued)

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, 2014. 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 = The end of the semi-monthly billing period in which employment terminates.
 2. Dependent no longer attends day care = The end of the semi-monthly billing period in which the dependent no longer attends day care.
 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, 2014. 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.

APPENDIX III (continued)

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.

NOTICE OF PRIVACY PRACTICES

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

APPENDIX IV (continued)

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;

APPENDIX IV (continued)

- **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;

APPENDIX IV (continued)

- **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;

APPENDIX IV (continued)

- **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.

APPENDIX IV (continued)

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;

APPENDIX IV (continued)

- 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.

APPENDIX IV (continued)

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;

APPENDIX IV (continued)

- 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.

APPENDIX IV (continued)

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;

APPENDIX IV (continued)

- **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.

Administered by:

Humana

Humana Insurance Company
500 West Main Street
Louisville, KY 40202

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