



**Humana**

**COMMONWEALTH OF KENTUCKY  
KENTUCKY EMPLOYEES' HEALTH PLAN  
(KEHP)  
HEALTHCARE FLEXIBLE SPENDING ACCOUNT  
SUMMARY PLAN DESCRIPTION**

Louisville Plan Number: 236117

Lexington Plan Number: 236134

Northern Kentucky Plan Number: 236215



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## INTRODUCTION

The Plan Sponsor has established and continues to maintain this Commonwealth of Kentucky (KEHP) Healthcare 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*.

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## PLAN INFORMATION

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### GENERAL INFORMATION ABOUT THE PLAN

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

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

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

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## PLAN INFORMATION (continued)

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### PLAN CONTACT INFORMATION

If you have any questions about the Commonwealth of Kentucky Healthcare 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 KY  
Personnel Cabinet, Department of Employee Insurance  
501 High Street  
Second Floor  
Frankfort, KY 40601  
888-581-8834  
502-564-6534

#### HUMANA / PLAN MANAGER

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

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## CAFETERIA PLAN SUMMARY

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### 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. See KRS 18A.225 and 18A.227.

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

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

### ENROLLMENT

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

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

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

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## **CAFETERIA PLAN SUMMARY (continued)**

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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 Healthcare FSA Eligibility Requirements, you are eligible to enroll in the Commonwealth of Kentucky Healthcare 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.

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## CAFETERIA PLAN SUMMARY (continued)

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

- (i) You experience a “*Qualifying Event*” that affects your eligibility under this Cafeteria Plan and/or a Benefit Plan Option; and
- (ii) You complete and submit a written Election Change Form within the Election Change period.

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

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

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

### LEAVE OF ABSENCE

The following is a general summary of the rules regarding participation in the Cafeteria Plan (and the Benefit Plan Options) during a leave of absence:

The specific election changes that you can make under this Cafeteria Plan following a leave of absence are:

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

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## CAFETERIA PLAN SUMMARY (continued)

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- (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 *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. Your Insurance Coordinator will let you know whether you are able to drop your coverage or whether you are required to continue coverage during the leave.

- (d) If your coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), you will be permitted to re-enter the Cafeteria Plan and the Benefit Plan Option upon return from such leave on the same basis as you were participating in the plans prior to the leave, or as otherwise required by the FMLA. Your coverage under the Benefit Plan Options providing health coverage may be automatically reinstated provided that coverage for *Employees* on non-FMLA leave is automatically reinstated upon return from leave.
- (e) The *Employer* may, on a uniform and consistent basis, continue your group health coverage for the duration of the leave following your failure to pay the required contribution. Upon return from leave, you will be required to repay the contribution in a manner agreed upon by you and the *Employer*.

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## CAFETERIA PLAN SUMMARY (continued)

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- (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.

### 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 last day of the semi-monthly pay period in which 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).

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## CAFETERIA PLAN SUMMARY (continued)

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### 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 1<sup>st</sup> day of the month following the month of the hire date. No election changes are permitted.

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

### TAX ADVANTAGES

You save both Federal income tax and FICA (Social Security) taxes by participating in the Cafeteria Plan. Cafeteria Plan participation will reduce the amount of your taxable *compensation*. Accordingly, there could be a decrease in your Social Security benefits and/or other benefits (e.g., pension, disability, and life insurance) that are based on taxable *compensation*. Participating in the Plan can actually increase your take home pay. Consider the following example for reference purposes only:

	No FSA	With FSA
Annual Salary	\$35,000	\$35,000
Pre-tax FSA withholding to cover out-of-pocket medical expenses		- \$1,000
Taxable Salary	\$35,000	\$34,000
Approximate Tax at 26%	- \$9,100	- \$8,840
Take Home Pay	\$25,900	\$25,160
Out-of-pocket medical expense after taxes	- \$1,000	
Money left in your pocket after medical expenses	\$24,900	\$25,160
Saved by participating in the FSA		\$260

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## HEALTHCARE FSA ELIGIBILITY REQUIREMENTS

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### PARTICIPATION

Each *employee* who satisfies the Healthcare FSA Eligibility requirements is eligible to participate on the Healthcare FSA Eligibility Date.

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

If you have otherwise satisfied the Healthcare FSA's Eligibility requirements, you become a *participant* in the Healthcare FSA by electing Healthcare Reimbursement benefits during the Initial or Annual Election Periods described in the Cafeteria Plan Summary. Your participation in the Healthcare FSA will be effective on the date that you make the election or your Healthcare 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 Healthcare FSA elections.

You may also become a participant if you experience a Qualifying Event that permits you to enroll midyear.

### ENROLLMENT

If you elect to participate in the Healthcare FSA, the *Employer* will establish a “Healthcare 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 Healthcare FSA are paid as needed from the *Employer's* general assets.

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

You may elect any annual reimbursement amount subject to the maximum annual Healthcare Reimbursement Amount allowed for the plan. The Maximum Annual Reimbursement Amount each year may not exceed the lesser of the Healthcare FSA reimbursement amount elected for that year or \$2,500. The minimum election amount is \$120 per year.

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

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## HEALTHCARE FSA ELIGIBILITY REQUIREMENTS (continued)

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Any change in your Healthcare FSA election also will change the maximum available reimbursement for the period of coverage after the election. Such maximum available reimbursements will be determined on a prospective basis only by a method determined by the *Plan Administrator* that is in accordance with applicable law. The *Plan Administrator* (or its designated claims administrator) will notify you of the applicable method when you make your election change.

### PERMITTED CARRYOVER

Notwithstanding any other provision of the Plan to the contrary, unused amounts of up to \$500 remaining in a Participant's Health FSA account at the end of the Plan Year can be used to reimburse the Participant for Medical Expenses that are incurred during the next Plan Year. The following conditions shall apply to Health FSA carryovers:

- (a) No more than \$500 of the Participant's unused Health FSA amount for a Plan Year may be carried over for use in the next Plan Year.
- (b) Carryovers may not be cashed out or converted to any other taxable or nontaxable benefit, and will not count toward the maximum dollar limit on annual Salary Reductions under the Health FSA.
- (c) Medical Expenses incurred in the current Plan Year will be reimbursed first from a Participant's unused amounts credited for that Plan Year and then from amounts carried over from the preceding Plan Year. Carryovers that are used to reimburse a current Plan Year expense will reduce the amount available to pay the Participant's preceding Plan Year expenses during the Run Out Period, cannot exceed \$500, and will count against the \$500 maximum carryover amount.

### ELIGIBLE DEPENDENTS

Dependent means the following:

1. Spouse -a person of the opposite sex to whom you are legally married.
2. Common Law Spouse - a person of the opposite sex with whom you have established a Common Law union **in a state which recognizes Common Law marriage** (Kentucky does not recognize Common Law Marriage).
3. Child Age 0 to 18 - in the case of a child who has not yet attained his/her 19th birthday, "child" means an individual who is:
  - (a) A son, daughter, stepson, or stepdaughter of the *employee/retiree*, or

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## HEALTHCARE FSA ELIGIBILITY REQUIREMENTS (continued)

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- (b) An eligible foster child of the *employee/retiree* (eligible foster child means an individual who is placed with the *employee/retiree* by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction), or
  - (c) An adopted child of the *employee/retiree* (a legally adopted individual of the *employee/retiree*, or an individual who is lawfully placed with the *employee/retiree* for legal adoption by the *employee/retiree*, shall be treated as a child), or
  - (d) A grandchild for whom the *employee/retiree* has been awarded guardianship or custody by a court of competent jurisdiction.
4. Child Age 19 to 25 - in the case of a child who has attained his/her 19th birthday but who has not yet attained his/her 26th birthday, “child” means an individual who is:
- (a) A son, daughter, stepson, stepdaughter, eligible foster child, adopted child or a grandchild of the *employee/retiree* – as described above; and
5. Disabled Dependent - A dependent child who is totally and permanently disabled may be covered on your KEHP benefit plan beyond the end of the month in which he/she turns 26, provided the disability (a) started before his/her 26th birthday and (b) is medically-certified by a physician. A dependent child will be considered totally and permanently disabled if, in the judgment of KEHP, the written certification adequately demonstrates that the Dependent child is unable to engage in any substantial gainful activity by reason of medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months.

### PLEASE NOTE:

- A Cross Reference Payment Option is a payment option involving two employees/retirees who are a legally married couple and enroll themselves and at least one child as a dependent in a KEHP family plan.
- A dependent must meet KEHP’s eligibility rules before an employee/plan holder may add the dependent to the Plan. Upon reaching age of termination the dependent child will become ineligible and be terminated as a dependent at the end of the month in which the birthday occurs.

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## HEALTHCARE FSA ELIGIBILITY REQUIREMENTS (continued)

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- Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. This includes adding a dependent to the Plan who does not meet the KEHP eligibility rules.
- The KEHP requires documentation to verify a dependent's eligibility before coverage will be provided under the Plan. Examples of such documentation include but are not limited to marriage certificate, birth certificate, court documents and/or guardianship papers.

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

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

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

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

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

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## **HEALTHCARE FSA ELIGIBILITY REQUIREMENTS (continued)**

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

### **The HEART Act**

The Heroes Earnings Assistance and Relief Tax Act of 2008 (the "HEART Act") amends Internal Revenue Code Section 125, among other sections, to permit plan sponsors to make a cash distribution of unused health FSA benefits to eligible individuals without disqualifying the cafeteria plan. Under the HEART Act, plan sponsors optionally may amend their health FSA and cafeteria plan documents to allow a distribution of unused health FSA funds from the plan to a qualified military reservist subject to certain conditions. Distributions that meet the requirements are called "qualified reservist distributions."

In order to be a "qualified reservist distribution," the following 4 requirements must be met:

1. A qualified reservist distribution can be made only to a member of a "reserve component" (as defined in section 101 of title 37 of the United States Code). This means a member of the Army National Guard; U.S. Army, Navy, Marine Corps, Air Force, or Coast Guard Reserve; Air National Guard of the United States; or the Reserve Corps of the Public Health Service.
2. The distributions can be made only to a reservist who has been ordered or called into active duty for (i) 180 days or more or (ii) for an indefinite period.
3. The amount of the distribution must be for "all or a portion of the balance in the employee's account."
4. The distribution must be made within the period beginning on the date the reservist is called or ordered to duty and ending on the last day that reimbursements could otherwise be made for the plan year that includes the first day of the distribution period.

### **ELECTION CHANGES**

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

- (i) For any reason during the Annual Election Period. The election change will be effective the first day of the Plan Year following the end of the Annual Election Period.
- (ii) Following a Qualifying Event. You may change your Healthcare FSA election during the Plan Year only if you experience an applicable Qualifying Event.

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

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## **HEALTHCARE FSA ELIGIBILITY REQUIREMENTS (continued)**

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Refer to the Cafeteria Plan Summary to determine what, if any, specific changes you can make during a leave of absence. If your Healthcare FSA coverage ceases during an FMLA leave, you may, upon returning from FMLA leave, elect to be reinstated in the Healthcare FSA at either

- (i) The same coverage level in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or
- (ii) At the same coverage level that is reduced pro-rata for the period of FMLA leave during which you did not make any contributions.

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

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

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

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

#### **Health Insurance Protection**

- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

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

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## HEALTHCARE FSA ELIGIBILITY REQUIREMENTS (continued)

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### TERMINATION OF COVERAGE

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

- (i) The date that you elect not to participate in accordance with the Cafeteria Plan Summary;
- (ii) The last day of the *Plan Year* unless you make an election during the Annual Election Period;
- (iii) The last day of the semi-monthly pay period in which you terminate employment with the Employer; or
- (iv) The date that you terminate employment; or
- (v) The date that the Plan is terminated or you or the class of eligible *employees* of which you are a member are specifically excluded from the Plan.

You may be entitled to elect Continuation Coverage under the Healthcare FSA once your coverage ends because you terminate employment or experience a reduction in hours of employment. Coverage for your Eligible Dependents ends on the earliest of the following to occur:

- (i) The date your coverage ends;
- (ii) The date that your dependents cease to be eligible dependents (e.g. you and your *spouse* divorce); or
- (iii) The date the Plan is terminated or amended to exclude the individual or the class of Dependents of which the individual is a member from coverage under the Healthcare FSA.

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

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## HEALTHCARE FSA REIMBURSEMENT

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### ELIGIBLE CLAIMS EXPENSE

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

- (i) The expense is for "Healthcare" as defined by *Code* Section 213(d), excluding Over-the-Counter drugs and medicines that have not been prescribed;
- (ii) The expense has not been reimbursed by any other source and you will not seek reimbursement for the expense from any other source.

The *Code* generally defines "Healthcare" as any amounts incurred to diagnose, treat, or prevent a specific medical condition or for purposes of affecting any function or structure of the body. This includes, but is not limited to, both prescription and Over-the-Counter drugs and Over-the-Counter products and devices (e.g., crutches, supplies such as bandages and diagnostic devices such as blood sugar test kits), but does not include Over-the-Counter drugs and medicines (unless they have been prescribed). Not every health related expense you or your eligible dependents incur constitutes an expense for “Healthcare.” For example, an expense is not for “Healthcare”, as that term is defined by the *Code*, if it is merely for the beneficial health of you and/or your eligible dependents (e.g. vitamins or nutritional supplements that are not taken to treat a specific medical condition) or for cosmetic purposes, unless necessary to correct a deformity arising from illness, injury, or birth defect. You may, at the discretion of the Humana or the *Plan Administrator*, be asked to provide additional documentation from a Healthcare provider showing that you have a medical condition and/or the particular item is necessary to treat a medical condition. Expenses for cosmetic purposes are also not reimbursable unless they are necessary to correct an abnormality caused by illness, injury or birth defect.

In addition, certain expenses that might otherwise constitute “Healthcare” as defined by the *Code* are not reimbursable under any Healthcare FSA (per IRS regulations):

- (i) Health insurance premiums;
- (i) Over-the-Counter drugs and medicines;
- (ii) Expenses incurred for qualified long term care services; and
- (iii) Any other expenses that are specifically excluded by the *Employer*.

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

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## HEALTHCARE FSA REIMBURSEMENT (continued)

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

### CLAIMS REIMBURSEMENT

Under this Healthcare FSA, you have two reimbursement options, the HumanaAccess card or Paper Claims. The HumanaAccess card is the preferred method to pay expenses. In order to be eligible for the HumanaAccess card, you must agree to abide by the terms and conditions of the Electronic Payment Card Program (the “Program”) as set forth herein and in the HumanaAccess Cardholder Agreement (the “Cardholder Agreement”) including any fees applicable to participate in the program, limitations as to card usage, the Plan’s right to withhold and offset for ineligible claims, etc. Alternatively you can complete and submit a written claim for reimbursement (see “Paper Claims” below for more information). The following is a summary of how both options work.

FSA claim is deemed filed when it is received by Humana. If your claim for reimbursement is approved, you will be provided reimbursement as soon as reasonably possible following the determination.

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

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

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

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## HEALTHCARE FSA REIMBURSEMENT (continued)

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### ELECTRONIC PAYMENT CARD

The HumanaAccess card allows you to pay for Eligible Healthcare Expenses at the time that you incur the expense. Here is how the Humana Access card works.

- (a) In order to be eligible for the Humana Access card, you must agree to abide by the terms and conditions of the Program as set forth herein and in the Humana Access Cardholder Agreement (the “Cardholder Agreement”) including any fees applicable to participate in the Program, limitations as to card usage, the Plan’s right to withhold and offset for ineligible claims, etc.

You must agree to abide by the terms of the Program both during the Initial Election Period and during each Annual Election Period. A Cardholder Agreement will be provided to you. The Humana Access card will be turned off effective the first day of each Plan Year if you do not affirmatively agree to abide by the terms of the Program during the preceding Annual Election Period. The Cardholder Agreement is part of the terms and conditions of your Plan and this SPD.

- (b) The Humana Access card will be turned off when employment or coverage terminates. The card will be turned off if you fail to provide the correct documentation to Humana, when necessary to substantiate claims. If Humana does not receive substantiation (verification) from you within thirty (30) days after you swipe the Humana Access card, then Humana will request this substantiation from you. If substantiation is not received within thirty (30) more days (for a total of 60 days from the initial Humana Access card swipe), then claims processing will be suspended. This suspension of claims will include the use of the Humana Access card as well as reimbursements for paper claims.
- (c) As specified in the Cardholder Agreement, you certify during the applicable Election Period that the amounts in your Healthcare FSA will only be used for Eligible Healthcare Expenses (i.e. healthcare expenses incurred by you, your spouse, and your dependents). You also certify that you have not been reimbursed for the expense and that you will not seek reimbursement for the expense from any other source. Failure to abide by this certification will result in termination of card use privileges.
- (d) Use of the Humana Access card for Health FSA expenses is limited to merchants who are healthcare providers (doctors, pharmacies, etc.). As set forth in the Cardholder Agreement, you may be able to use the Humana Access card at a regular retail store – e.g., a supermarket, grocery store, or discount store with a pharmacy – if the facility has installed the Inventory Information Approval System (IIAS). If the IIAS system is not installed at a regular retail store, you will need to submit Health FSA expenses for reimbursement using a paper claim.

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## HEALTHCARE FSA REIMBURSEMENT (continued)

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- (e) When you incur an Eligible Healthcare Expense at a doctor's office or pharmacy, such as a co-payment or prescription drug expense, you swipe the Humana Access card at the provider's office much like you would a typical credit or debit card. The provider is paid for the expense up to the maximum reimbursement amount available under the Plan (or as otherwise limited by the Program) at the time that you swipe the card. Every time you swipe the Humana Access card, you certify to the Plan that the expense for which payment under the Healthcare FSA is being made is an Eligible Healthcare Expense and that you have not been reimbursed from any other source nor will you seek reimbursement from another source.
- (f) You must obtain and retain a receipt/third party statement each time you swipe the Humana Access card. You must obtain a third party statement from the healthcare provider (e.g., receipt, invoice, etc.) that includes the following information each time you swipe the Humana Access card:
- (i) The nature of the expense (e.g., what type of service or treatment was provided).
  - (ii) The date the expense was incurred.
  - (iii) The amount of the expense.

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

- (g) There may be situations in which you will not be required to provide the written statement to the claims administrator. More detail as to which situations apply under your Plan is specified in the Cardholder Agreement:
- **Co-Pay Match:** As specified in the Cardholder Agreement, no written statement is necessary if the Humana Access Card payment matches a specific co-payment you have under the component healthcare plan for the particular service that was provided. For example, if you have a \$10 co-pay for physician office visits, and the payment was made to a physician office in the amount of \$10, you will not be required to provide the third party statement to the Claims Administrator.
  - **Previously Approved Claim Match:** As specified in the Cardholder Agreement, no written statement is required if the expense is the same as the amount, duration and provider as a previously approved expense. For example, the claims administrator approves a thirty (30) count prescription with 3 refills that was purchased at ABC Pharmacy. Each time the Humana Access card is swiped for subsequent refills at ABC Pharmacy the receipt need not be provided to the Claims Administrator if the expense incurred is the same amount.

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## HEALTHCARE FSA REIMBURSEMENT (continued)

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

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

- (h) You must pay back any improperly paid claims. If you are unable to provide adequate or timely substantiation as requested by the Claims Administrator, you must repay the Plan for the unsubstantiated expense. The deadline for repaying the Plan is set forth in the Cardholder Agreement. If you do not repay the Plan within the applicable time period, the Humana Access card may be turned off and an amount equal to the unsubstantiated expense will be offset against future eligible claims under the Healthcare FSA. The Plan further reserves the right to withhold the amount of any unsubstantiated expenses from your paycheck and to take any additional steps deemed necessary to properly account for any unsubstantiated expenses.
- (i) You can use either the Humana Access card or the paper claims approach. You have the choice as to how to submit your eligible claims. If you elect not to use the Humana Access card, you may also submit claims under the Paper Claims approach discussed above. Claims for which the Humana Access card has been used cannot be submitted as Paper Claims.

### PAPER CLAIMS

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

- (i) The nature of the expense (e.g. what type of service or treatment was provided);
- (ii) If the expense is for a prescribed Over-the-Counter drug, the written statement must indicate the name of the drug;
- (iii) The date the expense was incurred; and
- (iv) The amount of the expense.

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## HEALTHCARE FSA REIMBURSEMENT (continued)

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

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

- **DENY ACCESS TO THE HUMANA ACCESS CARD.** To ensure that no further violations occur, the Humana Access card must be deactivated until the amount of the improper payment is recovered. In the meantime, the participant must request reimbursements through other methods (e.g., by submitting paper claims).
- **REQUIRE REPAYMENT.** The employer may “demand” that the participant repay the improper payment. A letter to the participant will be sent identifying the amount, the reasons for requiring repayment, and the timeframe in which the repayment must be made.
- **WITHHOLD FROM PAY.** If the demand for repayment is unsuccessful, then an amount equal to the improper payment must be withheld from the participant’s pay or other compensation, to the full extent permitted under applicable law.
- **OFFSET.** If the improper payment is still outstanding and amounts are not available to be withheld, then the employer is to apply a substitution or offset approach against subsequent valid claims, up to the amount of the improper payment.
- **TREAT PAYMENT AS OTHER BUSINESS INDEBTEDNESS.** If the above correction efforts prove unsuccessful, then the employee remains indebted to the employer for the amount of the improper payment. In that event, and consistent with its business practices, the employer may treat the payment as it would treat any other business indebtedness.

### DENIED CLAIM

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

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## HEALTHCARE FSA REIMBURSEMENT (continued)

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### UNCLAIMED HEALTHCARE REIMBURSEMENTS

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

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

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## HEALTHCARE FSA CONTINUATION OF COVERAGE

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### COBRA CONTINUATION OF COVERAGE

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

### WHEN COVERAGE MAY BE CONTINUED

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

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

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

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## **HEALTHCARE FSA CONTINUATION OF COVERAGE**

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### **NOTICE REQUIREMENTS**

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

### **ELECTION PROCEDURES AND DEADLINES**

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

### **COST**

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

### **WHEN CONTINUATION OF COVERAGE ENDS**

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

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## **HEALTHCARE FSA CONTINUATION OF COVERAGE**

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

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

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## APPENDIX I

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### CLAIMS REVIEW PROCEDURE CHART

The *Effective Date* of this Appendix I is January 1, 2014. It should replace and supersede any other Appendix I with an earlier date. The Plan has established the following claims review procedure in the event you are denied a benefit under this Plan.

**Step 1:** *Notice is received from Humana.* If your claim is denied, you will receive written notice from Humana that your claim is denied as soon as reasonably possible but no later than thirty (30) days after receipt of the claim. For reasons beyond the control of Humana, Humana may take up to an additional 15 days to review your claim. You will be provided written notice of the need for additional time prior to the end of the 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).

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## APPENDIX I (continued)

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

Other important information regarding your appeals:

- Each level of appeal will be independent from the previous level (i.e., the same person(s) or subordinates of the same person(s) involved in a prior level of appeal will not be involved in the appeal);
- On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information; and
- You cannot pursue other legal remedies until you have exhausted these appeals procedures.

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## APPENDIX II

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### QUALIFYING EVENTS

The *Effective Date* of this Appendix II is January 1, 2014. It should replace and supersede any other Appendix II with an earlier date. This Plan has adopted qualifying events (i.e. election changes). 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:

#### **Healthcare Flexible Spending Account (HC FSA)**

- A. Events starting or increasing HC FSA contributions
1. Birth, adoption, placement for adoption = 1<sup>st</sup> day of the 1<sup>st</sup> month from the employee's signature date.
  2. Marriage, loss of other coverage, court or administrative orders for dependent(s) or foster child(ren), expiration of COBRA = 1<sup>st</sup> day of 1<sup>st</sup> month from the employee signature date.
  3. Different open enrollment = 1<sup>st</sup> day of the 1<sup>st</sup> month (match effective date of other employer's plan).
  4. Return from Leave Without Pay = 1<sup>st</sup> day of the 1<sup>st</sup> month from the employee's signature date.
  5. Return from Military Leave = Date of return to work.
- B. Events stopping or decreasing HC FSA contributions
1. Termination of employment = Date of termination of employment.
  2. Death = Date of death.
  3. Divorce, loss of dependent status = End of the semi-monthly pay period in which employment terminates.
  4. Gaining other health insurance coverage (Medicare/Medicaid/Tricare/etc.) = End of the month from the employee's signature date.
  5. Different open enrollment = Last day of the month (match other employer's plan).

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## APPENDIX II

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6. Begins Leave without Pay or Military Leave = Last date of work.

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## APPENDIX III

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### ELIGIBLE CLAIMS EXPENSES

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

Note: This is only a list of examples.

#### MYHUMANA

Visit Humana's website at [www.humana.com](http://www.humana.com) or call (877-597-7474) for additional information regarding the list of eligible expenses outlined.

MyHumana is personal, password-protected access on Humana's home page that provides information and tools to help covered persons make informed decisions. Go to [www.humana.com](http://www.humana.com) and click on "Log in or Register" to receive step by step instructions on how to set up *your* MyHumana page. After you have set up your page, log on at [www.humana.com](http://www.humana.com), anytime to check the status of your FSA account. You can also find financial tools to help with budgeting for healthcare and more.

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

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

#### Assistance for the Handicapped:

##### Allowable Expenses

- Cost of guide for a blind person
- Cost of note-taker for a deaf child in school
- Cost of Braille books and magazines in excess of cost of regular editions
- Seeing eye dog (cost of buying, training, and maintaining)

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## APPENDIX III (continued)

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- Hearing-trained cat or other animal to assist deaf person (cost of buying, training, and maintaining)
- Household visual alert system for deaf person
- Excess cost of specifically equipping automobile for handicapped person over the cost of ordinary automobile; device for lifting handicapped person into automobile
- Special devices, such as tape recorder and typewriter, for a blind person

### **Dental and Orthodontic Care:**

#### Allowable Expenses

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

#### Specifically Disallowed

- Teeth bleaching
- Tooth bonding that is not medically necessary

### **Fees/Services:**

#### Allowable Expenses

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

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## APPENDIX III (continued)

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### Specifically Disallowed

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

### **Hearing Care:**

#### Allowable Expenses

- Hearing aids
- Batteries for operation of hearing aids

### **Medical Equipment:**

#### Allowable Expenses

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

#### Specifically Disallowed

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

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## APPENDIX III (continued)

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### Miscellaneous Charges:

#### Allowable Expenses

- X-rays
- Expenses of services connected with donating an organ
- Cost of computer storage of medical records
- Cost of special diet, but only if it is medically necessary and only to the extent that costs exceed that of a normal diet
- Transportation expenses primarily for, and essential to, medical care including bus, taxi, train, plane fares, ambulance services, parking fees, and tolls
- Lodging expenses (not provided in a hospital or similar institution) while away from home if all of the following requirements are met:
  - Lodging is primarily for and essential to medical care.
  - Medical care is provided by a doctor in a licensed hospital or in a medical care facility related to, or the equivalent of, a licensed hospital.
  - Lodging is not lavish or extravagant under the circumstances.
  - There is no significant element of personal pleasure, recreation, or vacation in the travel away from home. The amount included in medical expenses cannot exceed \$50 for each night for each person. Lodging is included for a person for whom transportation expenses are a medical expense because that person is traveling with the person receiving medical care. For example, if a parent is traveling with a sick child, up to \$100 per night is included as a medical expense for lodging (meals are not deductible).
- Amounts paid for meals during inpatient care at hospital or similar institution, if the main reason for being there is to receive medical care

#### Specifically Disallowed

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

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## APPENDIX III (continued)

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

Effective January 1, 2011, FSA funds may no longer be used to purchase Over-the-Counter medications (OTCs). You may be able to obtain reimbursement with a receipt and a prescription.

#### Allowable Expenses

##### **Antiseptics**

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

##### **Asthma Medications**

- Bronchodilator / Expectorant tablets
- Bronchial asthma inhalers

##### **Cold, Flu, and Allergy Medications**

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

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## APPENDIX III (continued)

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### Diabetes

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

### Ear / Eye Care

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

### Health Aids

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

### Pain Relief

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

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## APPENDIX III (continued)

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### Personal Test Kits

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

### Skin Care

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

### Stomach Care

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

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## APPENDIX III (continued)

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### Specifically Disallowed

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

### **Physicals:**

#### Allowable Expenses

- Routine and preventive physicals
- School and work physicals

### **Prescription Drugs:**

#### Allowable Expenses

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

#### Specifically Disallowed

- Vitamins or experimental drugs

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## APPENDIX III (continued)

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### Psychiatric Care:

#### Allowable Expenses

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

#### Specifically Disallowed

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

### Treatments and Therapies:

#### Allowable Expenses

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

#### Specifically Disallowed

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

### Vision Care:

#### Allowable Expenses

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

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## APPENDIX III (continued)

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### Specifically Disallowed

- Lens replacement insurance

### **Dual Use – requires letter from your doctor:**

### Allowable Expenses

- Foot spa
- Gloves and masks
- Herbs
- Leg or arm braces
- Massagers
- Minerals
- Special supplements
- Special teeth cleaning system
- Sun tanning products
- Vitamins
- Weight loss maintenance programs

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## APPENDIX IV

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### DEFINITIONS

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

**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.

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## APPENDIX IV (continued)

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**Nonelective Contribution(s)** - means any amount that the Employer, in its sole discretion, may contribute on behalf of each Participant to provide benefits for such Participant and his or her Dependents, if applicable, under one or more of the Benefit Package Option(s) offered under the Plan. The amount of employer contribution that is applied towards the cost of the Benefit Package Option(s) for each Participant and/or level of coverage shall be subject to the sole discretion of the Employer and may be adjusted upward or downward at any time in the contributing Employer's sole discretion. The amount shall be calculated for each Plan Year in a uniform and nondiscriminatory manner and may be based upon the Participant's dependent status, commencement, or termination date of the Participant's employment during the Plan Year, and such other factors as the Employer shall prescribe. In no event will any Nonelective Contribution be disbursed to a Participant in the form of additional, taxable Compensation.

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

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

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

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

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

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

**Run Out Period** – is the period during which expenses incurred during a Plan Year must be submitted to be eligible for Reimbursement. The Run Out Period for active and terminated employees ends 90 days after the end of the Plan Year.

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## **APPENDIX IV (continued)**

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**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 V is January 1, 2014. It should replace and supersede any other Appendix V with an earlier date.

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

**PLEASE REVIEW IT CAREFULLY!**

**Effective August 1, 2013**

This Notice of Privacy Practices (the “Notice”) describes the legal obligations of the Kentucky Employees’ Health Plan (“KEHP” or “Plan”) and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and subsequent regulations. This Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice of Privacy Practices to you pursuant to HIPAA.

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

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## APPENDIX V (continued)

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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](http://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;

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## APPENDIX V (continued)

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- **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;

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## APPENDIX V (continued)

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- **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;

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## APPENDIX V (continued)

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- **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.

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## APPENDIX V (continued)

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### 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;

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## APPENDIX V (continued)

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- 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](http://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.

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## APPENDIX V (continued)

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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](http://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](http://www.kehp.ky.gov);

- **Inspect and Copy** your PHI in a designated record set except for:
  - Psychotherapy notes;
  - Information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding;
  - PHI that is subject to or exempt from the Clinical Laboratory Improvements Amendments of 1988;
  - PHI not maintained in a designated record set;
  - If access is temporarily suspended because research is in progress, provided you have agreed to the denial of access when consenting to participate in the research;

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## APPENDIX V (continued)

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- 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](http://www.kehp.ky.gov);

- **Amend** your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set. We may deny your request for amendment if we determine that the PHI or record that is the subject of the request:
  - Was not created by us, unless you provide a reasonable basis to believe that the originator of the PHI is no longer available to act on the requested amendment;
  - Is not part of the information that you would be permitted to inspect and copy;
  - Would not be available for inspection due to an exception; or
  - Is accurate and complete.

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

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

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

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## APPENDIX V (continued)

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

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**APPENDIX V (continued)**

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- **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, 3<sup>rd</sup> 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](http://www.hhs.gov).

*Administered by:*

**Humana**

Humana Insurance Company  
500 West Main Street  
Louisville, KY 40202

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