

Employee Benefits Guide

Plan Year:
January 1, 2026 - December 31, 2026



















Prepared by:
FOUNDATION
RISK PARTNERS



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Welcome to Oldham County Fiscal Court!



On behalf of the management team, let me say that we're glad you're here and we look forward to your contribution to our continued growth. In exchange for your effort, we will always endeavor to provide you with a safe and pleasant workplace and a competitive compensation package.

Oldham County Fiscal Court knows that our employees have different needs, so we offer employees a wide range of comprehensive benefit plans to let you choose the benefits that best suit your particular situation.

This booklet provides you with a summary of your benefits. Please review it carefully so you can choose the coverage that's right for you and your dependents.

Eligibility & How To Enroll



ELIGIBILITY

As an Oldham County Fiscal Court employee, you are eligible for benefits if you work at least 30 hours per week. The eligibility period for enrollment is first of the month following 30 days from date of hire.

You may enroll your eligible dependents for coverage once you are eligible. Your eligible dependents include:

- Your legal spouse
- Your children up to age 26

Once your benefit elections become effective, they remain in effect until the end of the plan year. You may only change coverage within 30 days of a qualified life event. Pre-tax benefits are in effect until the end of the year.

QUALIFIED LIFE EVENT

Generally, you may change your benefit elections only during the annual enrollment period. However, you may change your benefit elections during the year if you experience a qualified life event, including: marriage, divorce, legal separation, birth or adoption of a child, change in child's dependent status, death of spouse, child or other qualified dependent, commencement or termination of adoption proceedings, or change in spouse's benefits.

You must notify Human Resources within 30 days of the qualified life event. Depending on the type of event, you may be asked to provide proof of the event. If you do not contact Human Resources within 30 days of the qualified event, you will have to wait until the next annual enrollment period to make changes (unless you experience another qualified life event).

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 37 for additional information.

For more information, please contact **Tina Schaaf** at **(502) 222-9357**.

HOW TO ENROLL

Everyone must complete their elections on Employee Navigator. If you would like to join the plan, add or delete dependents, you must complete your election/change on Employee Navigator. Instructions can be found on page 34.



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Medical Insurance

United Healthcare / Policy # 932821



	HDHP
HRA Contribution (details on following pages)	Single: Up to \$6,000 (after \$2,000 deductible is met) Family: Up to \$12,000 (after \$4,000 deductible is met)
Physician Visit*	50% after deductible
24/7 UHC Virtual Visit*	Up to \$54 copay
Deductible* Individual Family	\$6,000 \$12,000
Coinsurance* The Plan Pays	50% after deductible
Preventive Care	Covered at 100% (Deductible Waived)
Urgent Care*	50% after deductible
Emergency Room*	50% after deductible
Out-of-Pocket Maximum* Individual Family	\$8,000 \$16,000
Prescription Drug* Tier 1 Tier 2 Tier 3 Tier 4	Deductible then \$10 copay \$40 copay \$85 copay \$250 copay

*Per ACA guidelines these costs apply to your out-of-pocket limit.
These are in-network benefits; for out-of-network benefits please see the complete benefit summary.

Plan Cost	Premium Per Paycheck (24 per year)
Employee Only	\$0.00
Employee + Spouse	\$111.21
Employee + Child(ren)	\$100.09
Family	\$244.86



To locate a network provider in your area, go to: www.myuhc.com

Select **Choice Plus** network.

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Focusing on regular preventive care can help you – and your family – stay healthier

Preventive care can help you avoid potentially serious health conditions and/or obtain early diagnosis and treatment. Generally, the sooner your doctor can identify and treat a medical condition, the better the outcome.

Under the Affordable Care Act (ACA),* most health plans provide coverage for certain preventive health care services at 100%, without any cost to you. Just obtain your preventive care from a health plan network provider. Diagnostic (non-preventive) services are also covered, but you may have to pay a copayment, coinsurance or deductible.

Preventive care guidelines for children**

Recommended preventive care services for children will vary based on age and may include some of the following:

- Age-appropriate well-child examination.
- Anemia screening.
- Autism and developmental screening for children under age 3.
- Behavioral counseling during well-child examination to prevent sexually transmitted infections.
- Behavioral counseling to prevent skin cancer at each well-child examination.
- Cholesterol screening for children 24 months and older.
- Fluoride application by primary care physician for children under age 6.
- Hearing screening by primary care physician.
- Newborn screenings, including metabolic screening panel, phenylketonuria (PKU), hypothyroid and sickle cell.
- Psychosocial/behavioral assessments during well-child examination.
- Assessments for tobacco, alcohol or drug use.
- Screening for obesity and counseling for children on promoting improvements in weight.
- Screening for sexually transmitted diseases, lead, depression and tuberculosis for certain children at high risk.
- Vaccines and immunizations. For more information, visit [cdc.gov/vaccines](https://www.cdc.gov/vaccines).
- Vision screening by a primary care physician.

Not all children require all of the services identified above.*** Your doctor should give you information about your child's growth, development and general health, and answer any questions you may have.

Help protect and maintain your child's health with regular preventive care visits with a network doctor

Preventive care screening guidelines and counseling services for adults**

A preventive health visit can help you see how healthy you are now and help identify any health issues before they become more serious. You and your doctor can then work together to choose the care that may be right for you. Recommended preventive care services may include the following:

- Abdominal aortic aneurysm screening for adults who are 65–75 years old and have ever smoked.
- Alcohol screening during wellness examinations, with brief counseling interventions for certain people.
- Bacteriuria screening during pregnancy.
- Blood pressure screening at each wellness examination. Certain people may also require ambulatory blood pressure measurements outside of a clinical setting. Check with your doctor.
- Breastfeeding counseling, support and supplies during pregnancy and after birth. Includes a personal-use electric breast pump.
- Breast cancer medications for risk reduction (counseling) for women at high risk of breast cancer, but low risk for adverse effects.
- Cervical cancer screening (Pap smear) for women who are 21–65 years old.
- Chlamydia and gonorrhea infection screening for sexually active women who are 24 and younger, and older women at increased risk.
- Cholesterol screening for adults who are 40–75 years old.
- Colorectal cancer screening for adults who are 45–75 years old. Ask your physician about screening methods and intervals for screening.
- Contraceptive methods that are FDA-approved for women, including education and counseling.
- Depression screening for all adults, in a primary care setting.
- Diabetes screening for adults who are 40–70 years old and overweight or obese, or for those of any age who have a history of gestational diabetes.
- Falls prevention counseling for community-dwelling older adults, during wellness examination.
- Genetic counseling and evaluation for BRCA testing and BRCA lab testing. Lab testing requires prior authorization.
- Gestational diabetes mellitus screening during pregnancy.
- Healthy diet behavioral counseling for people with cardiovascular disease risk factors, in a primary care setting.
- Healthy weight and weight gain during pregnancy behavioral counseling interventions, which adds coverage for nutrition counseling for pregnant women.
- Hepatitis B virus infection screening during pregnancy and for people at high risk.
- Hepatitis C virus infection screening for adults who are 18–79 years old.
- Human immunodeficiency virus (HIV) screening for all adults.
- Human papillomavirus DNA testing for women who are 30 and older.
- Latent tuberculosis infection screening for people at increased risk.
- Lung cancer screening with low-dose CT scan for people who are 50–80 years old with at least a 20 pack year history (with prior authorization).
- Mammography screening.
- Obesity screening and counseling at each wellness examination.
- Osteoporosis screening for women who are 65 and older and younger women at an increased risk.
- Perinatal depression counseling for pregnant or postpartum women at risk.
- Prevention of HIV and pre-exposure prophylaxis (PrEP), with antiretroviral therapy, monitoring and testing.
- Rh incapability screening during pregnancy.
- Screening for anxiety for women, during wellness examination.
- Screening for urinary incontinence for women, during wellness examination.
- Screening for intimate partner violence for women, during wellness examination.
- Sexually transmitted infections behavioral counseling for prevention for adults who are sexually active or otherwise at increased risk, in a primary care setting.
- Skin cancer behavioral counseling for prevention for young adults up to age 24 at each wellness examination.
- Syphilis screening for adults at an increased risk.
- Tobacco cessation, screening and behavioral counseling for adults who smoke, in a primary care setting (refer to pharmacy vendor for pharmacotherapy for tobacco cessation).
- Vaccines and immunizations that are FDA-approved and have explicit ACIP recommendations for routine use. For more information, visit [cdc.gov/vaccines](https://www.cdc.gov/vaccines).
- Wellness examinations.
- Well-woman visits, including routine prenatal visits.



Go digital, get more out of your health plan benefits



Digital tools to keep you connected

Your personalized digital tools – the **UnitedHealthcare® app** and **myuhc.com®** – give you access to resources designed to help you:

- View benefit info, claim details and account balances
- Search network providers and facilities for the type of care you may need
- Access your health plan ID card and add your plan details to your smartphone's digital wallet
- Learn about covered preventive care
- Compare cost estimates before you get care, which may help you save money

Register once to access both tools

Start by opening the **UnitedHealthcare app** or going to **myuhc.com** and then:

- Tap **Register Now** on the app, or select **Register** on the website
- Fill in the required fields and create your username and password
- Enter your contact information and select SMS text or phone call for two-factor authentication – then, agree to the terms and conditions
- Opt in to paperless delivery from your communication preferences

Now that you're registered, you'll be able to manage your plan all year long.

Get connected



Scan this code to download the **UnitedHealthcare app** or visit **myuhc.com**

**United
Healthcare®**

Certain preventive care items and services, including immunizations, are provided as specified by applicable law, including the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services may be based on your age and other health factors. Other routine services may be covered under your plan, and some plans may require copayments, coinsurance or deductibles for these benefits. Always review your benefit plan documents to determine your specific coverage details.

All UnitedHealthcare members can access a cost estimate online or on the mobile app. None of the cost estimates are intended to be a guarantee of your costs or benefits. Your actual costs may vary. When accessing a cost estimate, please refer to the Website or Mobile application terms of use under the Find Care & Costs section. Available only for insured plans and self-funded plans with Optum Rx integrated pharmacy benefits.

The UnitedHealthcare® app is available for download for iPhone® or Android®. iPhone is a registered trademark of Apple, Inc. Android is a registered trademark of Google LLC.

Health Plan coverage provided by or through a UnitedHealthcare company. Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates.

Administrative services provided by United HealthCare Services, Inc. or their affiliates, and UnitedHealthcare Service LLC in NY. Stop-loss insurance is underwritten by UnitedHealthcare Insurance Company or their affiliates, including UnitedHealthcare Life Insurance Company in NJ, and UnitedHealthcare Insurance Company of New York in NY.



Visit with a provider 24/7 — whenever, wherever

With 24/7 Virtual Visits, you can connect to a provider by phone or video¹ through **myuhc.com**[®] or the UnitedHealthcare[®] app



Another way to get care

Providers can treat a wide range of health conditions—including many of the same conditions as an emergency room (ER) or urgent care—and may even prescribe medications,² if needed. **With a UnitedHealthcare plan, your cost for a 24/7 Virtual Visit is usually \$54 or less.³**

Consider 24/7 Virtual Visits for these common conditions and more

- Cough
- Fatigue/weakness
- Congestion/sinus pain
- Headache
- Nasal discharge
- Fever
- Sore throat
- Difficulty sleeping
- Loss of appetite

\$54 or less

An estimated 25% of ER visits could be treated with a 24/7 Virtual Visit—bringing a potential \$2,000⁴ cost down to \$54 or less

Get started

Sign in at myuhc.com/virtualvisits | Call the number on your health plan ID card | Download the UnitedHealthcare app

United Healthcare[®]

¹ Data rates may apply.

² Certain prescriptions may not be available, and other restrictions may apply.

³ The Designated Virtual Visit Provider's reduced rate for a 24/7 Virtual Visit is subject to change.

⁴ Average allowed amounts charged by UnitedHealthcare Network Providers are not tied to a specific condition or treatment. Actual payments may vary depending upon benefit coverage. Estimated urgent care savings are based on a \$131 difference between an average urgent care visit cost of \$180 and a Virtual Visit cost of \$54; \$2,000 difference between the average emergency room visit and the average urgent care visit. The information and estimates provided are for general informational and illustrative purposes only and are not intended to be nor should be construed as medical advice or a substitute for your doctor's care. You should consult with an appropriate health care professional to determine what may be right for you. In an emergency, call 911 or go to the nearest emergency room.

The UnitedHealthcare[®] app is available for download for iPhone[®] or Android[®]. iPhone is a registered trademark of Apple, Inc. Android is a registered trademark of Google LLC.

24/7 Virtual Visits is a service available with a Designated Virtual Network Provider via video, or audio-only where permitted under state law. Unless otherwise required, benefits are available only when services are delivered through a Designated Virtual Network Provider. 24/7 Virtual Visits are not intended to address emergency or life-threatening medical conditions and should not be used in those circumstances. Services may not be available at all times, or in all locations, or for all members. Check your benefit plan to determine if these services are available.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates. Health Plan coverage provided by or through a UnitedHealthcare company.



Get in on UHC Rewards

Good news – your health plan comes with a way to earn up to \$1,000. UnitedHealthcare Rewards is included in your health plan at no additional cost.



There’s so much good to get

With UHC Rewards, a variety of actions – including things you may already be doing, like tracking your steps or sleep – lead to rewards. The activities you go for are up to you, and the same goes for ways to spend your earnings.

Here are just a few of the ways you can earn:

Connect a tracker	\$65
Take a health survey	\$25
Get an annual checkup	\$50
Get a biometric screening	\$75

Visit UHC Rewards for the full list of rewardable activities that are available to you – and look for new ways of earning rewards to be added throughout the year.

Earn up to
\$1,000
including
\$40
today
when you activate
UHC Rewards

There are 2 ways to get started



On the UnitedHealthcare® app

- Scan this code to download the app
- Sign in or register
- Select **UHC Rewards**
- Activate UHC Rewards and start earning
- Though not required, connect a tracker and get access to even more reward activities

On myuhc.com®

- Sign in or register
- Select **UHC Rewards**
- Activate UHC Rewards
- Choose reward activities that inspire you – and start earning



Your health

Get in on an experience that's designed to help inspire healthier habits

Your goals

Personalize how you earn by choosing the activities that are right for you

Your rewards

Earn up to \$1,000 for completing rewardable activities

Questions?

Call customer service at **1-866-230-2505**

United Healthcare®

UnitedHealthcare Rewards is a voluntary program. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical advice. You should consult an appropriate health care professional before beginning any exercise program and/or to determine what may be right for you. Receiving an activity tracker, certain credits and/or rewards and/or purchasing an activity tracker with earnings may have tax implications. You should consult with an appropriate tax professional to determine if you have any tax obligations under this program, as applicable. If any fraudulent activity is detected (e.g., misrepresented physical activity), you may be suspended and/or terminated from the program. If you are unable to meet a standard related to health factor to receive a reward under this program, you might qualify for an opportunity to receive the reward by different means. You may call us toll-free at 1-866-230-2505 or at the number on your health plan ID card, and we will work with you (and, if necessary, your doctor) to find another way for you to earn the same reward. Rewards may be limited due to incentive limits under applicable law. Components subject to change. This program is not available for fully insured members in Hawaii, Vermont and Puerto Rico nor available to level funded members in District of Columbia, Hawaii, Vermont and Puerto Rico.

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Administrative services provided by United HealthCare Services, Inc. or their affiliates.

Administrative services provided by United HealthCare Services, Inc. or their affiliates, and UnitedHealthcare Service LLC in NY. Stop-loss insurance is underwritten by UnitedHealthcare Insurance Company or their affiliates, including UnitedHealthcare Life Insurance Company in NJ, and UnitedHealthcare Insurance Company of New York in NY.



Healthier habits, healthier lifestyle

Take small steps for lasting change with Real Appeal®, an online weight management support program.



Get healthier, at no additional cost to you

Real Appeal on Rally Coach™ is a proven weight management program designed to help you get healthier and stay healthier. It's available to you and eligible family members at no additional cost as part of your benefits.

Take small steps toward healthier habits

Set achievable nutrition, exercise and weight management goals that keep you motivated to create lasting change. Track your progress from your daily dashboard, too.

Support and community along the way


Feel supported with personalized messages, online group sessions led by coaches and a caring community of members.

Join today at enroll.realappeal.com or scan this code



Real Appeal is a voluntary weight loss program that is offered to eligible members at no additional cost as part of their benefit plan. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical and/or nutritional advice. Participants should consult an appropriate health care professional to determine what may be right for them. Results, if any, may vary. Any items/tools that are provided may be taxable and participants should consult an appropriate tax professional to determine any tax obligations they may have from receiving items/tools under the program.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates.



Get a Success Kit delivered right to your door.

Make the most of tools and resources like weight and food scales, a portion plate and more. Your Success Kit is delivered after you attend your first live group session.

United
Healthcare

Real
Appeal®

The path to quitting starts here



If you use tobacco and have thought about quitting, **Quit For Life® on Rally Coach™** may be able to help. Get tools and online resources designed to help you quit – and stay quit – at no additional cost.



Get coach support

Connect with a coach who will help create a personalized Quit Plan and guide you at every step



Access anytime, anywhere

Manage triggers with help from coach-led group sessions, trackers, text support, and more, all at your fingertips



View quit recommendations

Get real-life tips and plan your path to quit with recommended daily goals, articles and videos



Stay on track with **24/7** support

Quit For Life®

Get started

Go to [Myuhc.com](https://myuhc.com) > Coverage & Benefits > My Coverage & Benefits > Additional Benefits > View all additional benefits



This service should not be used for emergency or urgent care needs. In an emergency, call 911 or go to the nearest emergency room. The information provided through this program is for informational purposes only as part of your health plan. Wellness coaches, nurses and other program representatives cannot diagnose problems or recommend treatment and are not a substitute for your doctor's care. Please discuss with your doctor how the information provided may be right for you. Your health information is kept confidential in accordance with the law. The program is not an insurance program and may be discontinued at any time.

Administrative services provided by UnitedHealthcare Services, Inc. or their affiliates. Insurance coverage provided through UnitedHealthcare Insurance Company or its affiliates.

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Health Savings Account (HSA)

Optum Financial



A Health Savings Account (HSA) is an account that can be funded by you, your employer, or both, with tax-exempt dollars. Funds from the account can help pay for eligible medical expenses that are not covered by your insurance plan including deductible, coinsurance, and even dental and vision services.

ADVANTAGES OF AN HSA:

- Money can be invested much like 401(k) funds (based on your specific financial institution)
- You can change your HSA contribution amount during any payroll period
- Unused money is not forfeited at the end of the year and is carried forward

Keep in mind, an HSA can only be used in conjunction with a High-Deductible Health Plan, which for Oldham County Fiscal Court is the HDHP Health Plan.

Any funds used on non-qualified expenses are subject to taxation and a 20% penalty from the IRS.

INELIGIBLE FOR AN HSA:

- Enrolled in Medicare or Tricare
- Enrolled in another PPO Plan
- Enrolled in an FSA
- Claimed as a dependent on someone else's tax return

CONTRIBUTIONS

- The maximum amount that can be contributed in 2026 is \$4,400 for a single contract and \$8,750 for a family.
- Individuals 55 and over can make an additional \$1,000 catch-up contribution annually until age 65.

Please keep in mind the total annual contribution to your HSA cannot exceed the IRS limits listed above.



To see a list of eligible HSA expenses, please visit <https://hsastore.com/HSA-Eligibility-List.aspx>

How It Works

When visiting a physician, hospital, or other facility:

- When arriving for your appointment, provide them with your health insurance card.
- After your visit, your claim will be submitted to your insurance carrier for processing
- After the health care provider has received notification from your insurance carrier that the claim has been processed, you will receive a billing statement outlining the balance for which you are responsible.
- You then use your bank card/HSA check to pay for these expenses.

When going to the Pharmacy:

- When picking up your medication, provide them with your health insurance card.
- The pharmacy will run it through their system and provide you with a balance due.
- You then use your bank card/HSA check to pay for these expenses at that time.



YOU SAVE...

One option for employee contributions is via pre-tax payroll deduction through a Section 125 plan. One advantage of this plan is your contributions are not subject to individual or employment taxes. This means if you contribute \$1,000 of your gross pay into the HSA, the impact on your net pay is about \$700 since you did not have to pay tax on your HSA contributions. In this example, you would save about \$300.

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Health Reimbursement Arrangement (HRA)

McGregor & Associates



Oldham County Fiscal Court will include a Health Reimbursement Arrangement to assist employees and dependents to cover the cost of the deductible and out of pocket costs for the 2026 United Health Care Health plan.

For Single Coverage - the plan has an upfront deductible of \$6,000, 50% coinsurance (\$2,000) after the deductible, and total maximum out of pocket of \$8,000. The HRA will reimburse you after you reach \$2,000 in total cost. The remaining \$6,000 is covered through reimbursements of the HRA. The United Health Care plan will pay at 100% thereafter for normal covered claims.

Employee Only Coverage

Expenses	Employee %	Employee Pays	HRA %	HRA Pays
\$2,000	100%	\$2,000	0%	\$0.00
\$6,000	0%	\$0.00	100%	\$6,000
\$8,000		\$2,000		\$6,000

For Employee & Dependent(s) Coverage (Family) - the plan has an upfront family deductible of \$12,000 and total maximum out of pocket of \$16,000. The HRA will begin reimbursement after the family incurs claims exceeding \$3,400. The HRA will then payout up to \$4,600. After the initial \$4,600 HRA has been used, the family is responsible for the next \$600 in claims. The HRA will begin reimbursement for the remaining \$7,400 which is a total \$12,000 in reimbursements. The United Health Care plan will pay at 100% thereafter for normal covered claims.

Employee & Dependent(s) Coverage (Family)

Family Member #1 or multiple family members (combination of one or all family members)

Expenses	Employee %	Employee Pays	HRA %	HRA Pays
\$3,400	100%	\$3,400	0%	\$0.00
\$4,600	0%	\$0.00	100%	\$4,600
\$8,000		\$3,400		\$4,600

Family Members (or combination of all other family members) Once \$4,600 is reimbursed, the family is responsible for \$600 and is eligible for remaining \$7,400 in future claims for 2026.

Expenses	Employee %	Employee Pays	HRA %	HRA Pays
\$600	100%	\$600	0%	\$0.00
\$7,400	0%	\$0.00	100%	\$7,400
\$8,000		\$600		\$7,400

Reimbursements will be reimbursed via direct deposit or check. Please verify your account information by going to the McGregor online portal. McGregor will use previous account information for the upcoming plan year.

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How to Access Your Account Online

Accessing your benefit account(s) is easy! Register for online access at our website, www.mcgregoreba.com.

Here you can access account history, upload claims, and provide required documentation at your convenience, 24 hours a day, 7 days a week.

To Register:

Visit www.mcgregoreba.com and click on Login Portals:



ABOUT SERVICES RESOURCES CAREERS CONTACT US

LOGIN PORTALS

Choose **FSA/HRA Employee Portal Login**



Username: *First Initial, Last Name, Last 4 SSN*

Ex: mjackson1234

Password: *Social Security number, no dashes*

Ex: 987651234

Once signed in, you will be prompted for a new password and security questions. After completion, you can sign in online and into the mobile app! You may also add direct deposit information, by going to Accounts and add your bank account and update your payment method to indicate direct deposit.

McGregor & Associates, Inc.

997 Governors Lane, Suite 175 Lexington, KY 40513

Toll Free: 1-(877) 781-3399 Fax: (877) 224-FLEX (3539)

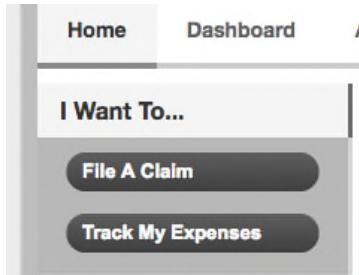
www.mcgregoreba.com  

Filing a Claim on the Website and Mobile App

1 Sign In

- a. First time login
 - i. Username: (first initial)(last name)(last 4 of SSN)
 1. mjackson1234
 - ii. Password: SSN (no dashes)
 1. 987651234
 - iii. Create Personal Password
 - iv. Answer Security Questions

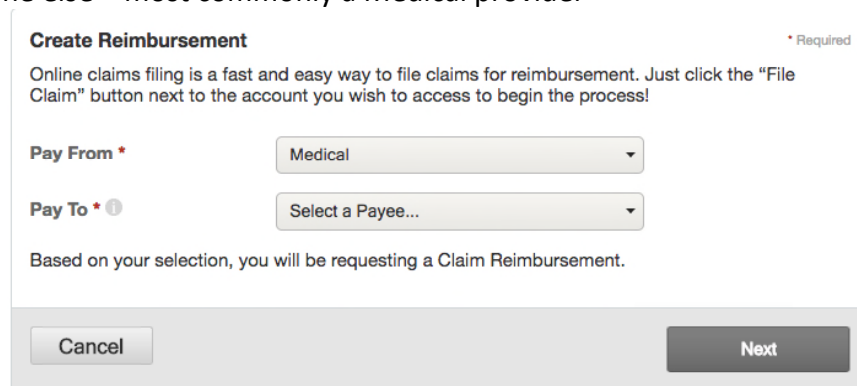
2 Go to “File a Claim”



a.

3 Choose “Medical” and “Pay to”

- a. Me – you/your family want to receive payment
- b. Someone else – most commonly a Medical provider

A screenshot of a "Create Reimbursement" form. The form has a title "Create Reimbursement" with a red asterisk and the word "Required" to its right. Below the title is a paragraph of text: "Online claims filing is a fast and easy way to file claims for reimbursement. Just click the 'File Claim' button next to the account you wish to access to begin the process!". There are two dropdown menus: "Pay From *" with "Medical" selected, and "Pay To * ⓘ" with "Select a Payee..." selected. Below the dropdowns is a line of text: "Based on your selection, you will be requesting a Claim Reimbursement." At the bottom of the form are two buttons: "Cancel" and "Next".

i.

4 Upload Valid Documentation

- a. Receipts must include:
 - i. Service Provider
 - ii. Date of Service
 - iii. Patient Name
 - iv. Line Item descriptions and costs
 1. Most commonly, an Explanation of Benefit (EOB) works great!
- b. Mobile App – Use your phone’s camera to take a picture of your documentation!

5 Fill out details for the Claim

- a. Required fields marked by *
- b. Amount: file for the total amount of the bill, not just your reimbursement amount.

6 Submit

Dental Insurance

Humana Dental



	CORE	BUY-UP
Deductible (Single/Family)		
In-Network*	\$50 / \$150	\$50 / \$150
Out-of-Network	\$50 / \$150	\$50 / \$150
Annual Benefit Maximum	\$1,000	\$1,500
Preventive Services		
In-Network*	100%, deductible waived	100%, deductible waived
Out-of-Network	80%, deductible waived	100%, deductible waived
Basic Services		
In-Network*	80% after deductible	80% after deductible
Out-of-Network	60% after deductible	80% after deductible
Major Services		
In-Network*	50% after deductible	50% after deductible
Out-of-Network	50% after deductible	50% after deductible
Orthodontia (children through age 18)		
In-Network*	50%	50%
Out-of-Network	50%	50%
Child Orthodontia Lifetime Maximum	\$1,000	\$1,500
Out-of-Network Fee Schedule	Same as in-network	90 th percentile of UCR

*As noted above these are In-Network benefits. For Out-of-Network benefits please see the complete benefit summary. Please note when seeing an Out-of-Network dentist you may be billed the full amount at the time of service and then have to wait to be reimbursed.

What do I need when I go to the dentist?

Nothing. You do not need an ID card or a claim form to receive treatment. However, at your first visit after your dental coverage takes effect, it would be helpful if you provide your dentist with your group number and member ID number for their records.

Plan Cost	Core Premium Per Paycheck (24 per year)	Buy-Up Premium Per Paycheck (24 per year)
Employee Only	\$6.02	\$8.74
Employee + Spouse	\$20.04	\$25.91
Employee + Child(ren)	\$19.35	\$24.46
Family	\$34.44	\$42.72



To locate a network provider in your area go to: www.humana.com/findadentist.

Choose Network: PPO/Traditional Preferred

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Humana Vision 130 Plan

Benefit Design	In-Network*
Frequency	
Exam	12 months
Lenses	12 months
Frames	24 months
Exam with dilation as necessary	\$10 copay
Contact Lens Exam (Standard lens fit & follow up)	Up to \$40
Retinal Screening Imaging	\$39 copay
Frames	\$130 allowance, then 20% off balance over \$130
Lenses	
Single Vision	\$15 copay
Bifocal	\$15 copay
Trifocal	\$15 copay
Lenticular	\$15 copay
Medically Necessary Contact Lenses	\$0 copay
Contact Lenses	
Conventional	Up to \$130 allowance, 15% off balance over \$130
Disposable	\$130 allowance
Laser Vision Discount	May receive up to 15% off retail price or 5% off promotional price for Lasik or PRK from the US Laser Network.

*As noted above these are in-network benefits; for out-of-network benefits please see the complete benefit summary.

Plan Cost	Premium Per Paycheck (24 per year)
Employee Only	\$2.89
Employee + Spouse	\$5.77
Employee + Child(ren)	\$6.24
Family	\$9.36



To locate a network provider in your area go to:
[Humana.com/findcare](https://www.humana.com/findcare)

Choose Humana Vision (Humana Insight Network)

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Basic Life and AD&D Insurance

One America / Policy # 617892



Life insurance is an important part of your financial security, especially if others depend on you for support. Accidental Death & Dismemberment (AD&D) insurance is designed to provide a benefit in the event of accidental death or dismemberment. Our company provides Basic Life and AD&D insurance to all eligible employees working 30 or more hours per week at no cost to you.

This benefit includes:

- **Basic Life: \$50,000**
- **AD&D: \$50,000**
- **Reduction Schedule:** Reduces by 35% at age 65; reduces by 55% of the original amount at age 70; reduces by 70% of the original amount at age 75; reduces by 80% of the original amount at age 80; reduces by 85% of the original amount at age 85. Benefits terminate at retirement.
- **Conversion:** You may be entitled to convert your life amount. Please contact One America within 30 days of when you leave employment.

Voluntary Life Insurance Coverage

One America / Policy # 617892



Employees may purchase additional Life insurance. New hires are able to enroll up to the guaranteed issue amount without Evidence of Insurability. Any amounts elected over the guaranteed issue amount requires Evidence of Insurability form to be completed. Employees that previously waived Voluntary Life that want to elect at Open Enrollment will need to complete an Evidence of Insurability form. Employees currently enrolled on Voluntary Life are able to increase \$10,000 without EOI up to the maximum amount of \$150,000. Employees currently enrolled electing to increase their benefit over \$10,000 must complete an Evidence of Insurability form. If your Evidence of Insurability is approved, your effective date is the first of the month following approval.

- Employees may elect \$10,000 - \$150,000 up to 5 times basic annual earnings.
- The guaranteed issue for employees under age 70 is \$100,000.
- Employees may elect Spousal Life at \$5,000 - \$50,000 up to 50% of the employee amount.
- The guaranteed issue for spouses is \$25,000.
- Employees may elect up to \$10,000 for each dependent child up to age 26.
- **Reduction Schedule:** Employee: Reduces to 40% at age 70; to 25% at age 75 and to 15% at age 80. Spouse The amount of dependent life will reduce according to the employee's reduction schedule when the employee reaches age 70. Benefits terminate at employee retirement.
- **Portability and Conversion:** You may be entitled to convert or port your life amount. Please contact One America within 30 days of when you leave employment.

Voluntary Term Life Rates

Note: Premiums are based on your age as of 01/01 and amount of coverage chosen. You may select a minimum benefit of \$10,000 up to a maximum amount of \$150,000, in \$1,000 increments, not to exceed 5 times your annual base salary only, rounded to the next higher \$10,000.



Payroll Deduction Illustration: 2 Times Per Month Employee Options - Employee Rates

	0-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75 +
\$10,000	\$0.40	\$0.40	\$0.35	\$0.40	\$0.50	\$0.75	\$1.15	\$1.85	\$2.90	\$4.45	\$7.35	\$14.30	\$27.65
\$20,000	\$0.80	\$0.80	\$0.70	\$0.80	\$1.00	\$1.50	\$2.30	\$3.70	\$5.80	\$8.90	\$14.70	\$28.60	\$55.30
\$30,000	\$1.20	\$1.20	\$1.05	\$1.20	\$1.50	\$2.25	\$3.45	\$5.55	\$8.70	\$13.35	\$22.05	\$42.90	\$82.95
\$40,000	\$1.60	\$1.60	\$1.40	\$1.60	\$2.00	\$3.00	\$4.60	\$7.40	\$11.60	\$17.80	\$29.40	\$57.20	\$110.60
\$50,000	\$2.00	\$2.00	\$1.75	\$2.00	\$2.50	\$3.75	\$5.75	\$9.25	\$14.50	\$22.25	\$36.75	\$71.50	\$138.25
\$60,000	\$2.40	\$2.40	\$2.10	\$2.40	\$3.00	\$4.50	\$6.90	\$11.10	\$17.40	\$26.70	\$44.10	\$85.80	\$165.90
\$70,000	\$2.80	\$2.80	\$2.45	\$2.80	\$3.50	\$5.25	\$8.05	\$12.95	\$20.30	\$31.15	\$51.45	\$100.10	\$193.55
\$80,000	\$3.20	\$3.20	\$2.80	\$3.20	\$4.00	\$6.00	\$9.20	\$14.80	\$23.20	\$35.60	\$58.80	\$114.40	\$221.20
\$90,000	\$3.60	\$3.60	\$3.15	\$3.60	\$4.50	\$6.75	\$10.35	\$16.65	\$26.10	\$40.05	\$66.15	\$128.70	\$248.85
\$100,000	\$4.00	\$4.00	\$3.50	\$4.00	\$5.00	\$7.50	\$11.50	\$18.50	\$29.00	\$44.50	\$73.50	\$143.00	\$276.50

The amounts below require Statement of Insurability form

\$110,000	\$4.40	\$4.40	\$3.85	\$4.40	\$5.50	\$8.25	\$12.65	\$20.35	\$31.90	\$48.95	\$80.85	\$157.30	\$304.15
\$120,000	\$4.80	\$4.80	\$4.20	\$4.80	\$6.00	\$9.00	\$13.80	\$22.20	\$34.80	\$53.40	\$88.20	\$171.60	\$331.80
\$130,000	\$5.20	\$5.20	\$4.55	\$5.20	\$6.50	\$9.75	\$14.95	\$24.05	\$37.70	\$57.85	\$95.55	\$185.90	\$359.45
\$140,000	\$5.60	\$5.60	\$4.90	\$5.60	\$7.00	\$10.50	\$16.10	\$25.90	\$40.60	\$62.30	\$102.90	\$200.20	\$387.10
\$150,000	\$6.00	\$6.00	\$5.25	\$6.00	\$7.50	\$11.25	\$17.25	\$27.75	\$43.50	\$66.75	\$110.25	\$214.50	\$414.75

Payroll Deduction Illustration: 2 Times Per Month Spouse Options - Spouse Rates

	0-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75 +
\$5,000	\$0.20	\$0.20	\$0.18	\$0.20	\$0.25	\$0.38	\$0.58	\$0.93	\$1.45	\$2.23	\$3.68	\$3.68	\$3.68
\$10,000	\$0.40	\$0.40	\$0.35	\$0.40	\$0.50	\$0.75	\$1.15	\$1.85	\$2.90	\$4.45	\$7.35	\$7.35	\$7.35
\$15,000	\$0.60	\$0.60	\$0.53	\$0.60	\$0.75	\$1.13	\$1.73	\$2.78	\$4.35	\$6.68	\$11.03	\$11.03	\$11.03
\$20,000	\$0.80	\$0.80	\$0.70	\$0.80	\$1.00	\$1.50	\$2.30	\$3.70	\$5.80	\$8.90	\$14.70	\$14.70	\$14.70
\$25,000	\$1.00	\$1.00	\$0.88	\$1.00	\$1.25	\$1.88	\$2.88	\$4.63	\$7.25	\$11.13	\$18.38	\$18.38	\$18.38

The amounts below require Statement of Insurability form

\$30,000	\$1.20	\$1.20	\$1.05	\$1.20	\$1.50	\$2.25	\$3.45	\$5.55	\$8.70	\$13.35	\$22.05	\$22.05	\$22.05
\$35,000	\$1.40	\$1.40	\$1.23	\$1.40	\$1.75	\$2.63	\$4.03	\$6.48	\$10.15	\$15.58	\$25.73	\$25.73	\$25.73
\$40,000	\$1.60	\$1.60	\$1.40	\$1.60	\$2.00	\$3.00	\$4.60	\$7.40	\$11.60	\$17.80	\$29.40	\$29.40	\$29.40
\$45,000	\$1.80	\$1.80	\$1.58	\$1.80	\$2.25	\$3.38	\$5.18	\$8.33	\$13.05	\$20.03	\$33.08	\$33.08	\$33.08
\$50,000	\$2.00	\$2.00	\$1.75	\$2.00	\$2.50	\$3.75	\$5.75	\$9.25	\$14.50	\$22.25	\$36.75	\$36.75	\$36.75

Child Rates

	Child(ren) 6 months to age 26	Child(ren) live birth to 6months	Deduction amount Child(ren)
Option 1	\$5,000	\$1,000	\$0.53
Option 2	\$10,000	\$1,000	\$1.05

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Voluntary Short-Term Disability Insurance Coverage

One America / Policy # 617892



The goal of the company's Disability Insurance Plan is to provide you with income replacement should you become disabled and unable to work due to a non-work-related illness or injury.

Voluntary Short-Term Disability (STD):

- 60% of covered weekly earnings up to \$1,150
- Elimination period before benefits begin:
14 days accident / 14 days illness
- Payable to 13 weeks
- 12/12 Pre-Existing: Benefits will not be paid if the disability begins in the first 12 months of coverage and was treated in the 12 months just prior to the effective date of coverage.

Voluntary Short-Term Disability Rates

If your annual salary is at least:	You may select a weekly benefit of:	0-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
\$26,000	\$300	\$11.85	\$11.85	\$11.85	\$11.85	\$13.05	\$13.05	\$13.50	\$13.50	\$14.70	\$14.70	\$18.15	\$18.15
\$30,333	\$350	\$13.83	\$13.83	\$13.83	\$13.83	\$15.23	\$15.23	\$15.23	\$15.75	\$17.15	\$17.15	\$21.18	\$21.18
\$34,667	\$400	\$15.80	\$15.80	\$15.80	\$15.80	\$17.40	\$17.40	\$18.00	\$18.00	\$19.60	\$19.60	\$24.20	\$24.20
\$39,000	\$450	\$17.78	\$17.78	\$17.78	\$17.78	\$19.58	\$19.58	\$20.25	\$20.25	\$20.05	\$20.05	\$27.23	\$27.23
\$43,333	\$500	\$19.75	\$19.75	\$19.75	\$19.75	\$21.75	\$21.75	\$22.50	\$22.50	\$24.50	\$24.50	\$30.25	\$30.25
\$47,677	\$550	\$21.73	\$21.73	\$21.73	\$21.73	\$23.93	\$23.93	\$24.75	\$24.75	\$26.95	\$26.95	\$33.28	\$33.28
\$52,000	\$600	\$23.70	\$23.70	\$23.70	\$23.70	\$26.10	\$26.10	\$27.00	\$27.00	\$29.40	\$29.40	\$36.30	\$36.30
\$56,333	\$650	\$25.68	\$25.68	\$25.68	\$25.68	\$28.28	\$28.28	\$29.25	\$29.25	\$31.85	\$31.85	\$39.33	\$39.33
\$60,677	\$700	\$27.65	\$27.65	\$27.65	\$27.65	\$30.45	\$30.45	\$31.50	\$31.50	\$34.30	\$34.30	\$42.35	\$42.35
\$65,000	\$750	\$29.63	\$29.63	\$29.63	\$29.63	\$32.63	\$32.63	\$33.75	\$33.75	\$36.75	\$36.75	\$45.38	\$45.38
\$69,333	\$800	\$31.60	\$31.60	\$31.60	\$31.60	\$34.80	\$34.80	\$36.00	\$36.00	\$39.20	\$39.20	\$48.40	\$48.40
\$73,667	\$850	\$33.58	\$33.58	\$33.58	\$33.58	\$36.98	\$36.98	\$38.25	\$38.25	\$41.65	\$41.65	\$51.43	\$51.43
\$78,000	\$900	\$35.55	\$35.55	\$35.55	\$35.55	\$39.15	\$39.15	\$40.50	\$40.50	\$44.10	\$44.10	\$54.45	\$54.45
\$82,333	\$950	\$37.53	\$37.53	\$37.53	\$37.53	\$41.33	\$41.33	\$42.75	\$42.75	\$46.55	\$46.55	\$57.48	\$57.48
\$86,677	\$1,000	\$39.50	\$39.50	\$39.50	\$39.50	\$43.50	\$43.50	\$45.00	\$45.00	\$49.00	\$49.00	\$60.50	\$60.50
\$91,000	\$1,050	\$41.48	\$41.48	\$41.48	\$41.48	\$45.68	\$45.68	\$47.25	\$47.25	\$51.45	\$51.45	\$63.53	\$63.53
\$69,533	\$1,100	\$43.45	\$43.45	\$43.45	\$43.45	\$47.85	\$47.85	\$49.50	\$49.50	\$53.90	\$53.90	\$66.55	\$66.55
\$99,667	\$1,150	\$45.43	\$45.43	\$45.43	\$45.43	\$50.03	\$50.03	\$51.75	\$51.75	\$56.35	\$56.35	\$69.58	\$69.58

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Voluntary Long-Term Disability Insurance Coverage

One America / Policy # 617892



The goal of the company's Disability Insurance Plan is to provide you with income replacement should you become disabled and unable to work due to a non-work-related illness or injury.

Voluntary Long-Term Disability (LTD):

- 60% of base monthly earnings up to \$5,000
- Elimination period before benefits begin: 90 days
- Maximum Benefit Duration: Social Security Full Retirement Age
- 3/12 Pre-Existing: Benefits will not be paid if the disability begins in the first 12 months of coverage and was treated in the 3 months just prior to the effective date of coverage.

Voluntary Long-Term Disability Rates

If your annual salary is at least:	You may select a weekly benefit of:	0-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
\$6,000	\$300	\$0.21	\$0.33	\$0.57	\$1.02	\$1.31	\$2.03	\$3.38	\$4.31	\$4.49	\$4.49	\$2.82	\$2.03
\$8,000	\$400	\$0.28	\$0.44	\$0.76	\$1.36	\$1.74	\$2.70	\$4.50	\$5.74	\$5.98	\$5.98	\$3.76	\$2.70
\$10,000	\$500	\$0.35	\$0.55	\$0.95	\$1.70	\$2.18	\$3.38	\$5.63	\$7.18	\$7.48	\$7.48	\$4.70	\$3.38
\$12,000	\$600	\$0.42	\$0.66	\$1.14	\$2.04	\$2.61	\$4.05	\$6.75	\$8.61	\$8.97	\$8.97	\$5.64	\$4.05
\$14,000	\$700	\$0.49	\$0.77	\$1.33	\$2.38	\$3.05	\$4.73	\$7.88	\$10.05	\$10.47	\$10.47	\$6.58	\$4.73
\$16,000	\$800	\$0.56	\$0.88	\$1.52	\$2.72	\$3.48	\$5.40	\$9.00	\$11.48	\$11.96	\$11.96	\$7.52	\$5.40
\$18,000	\$900	\$0.63	\$0.99	\$1.71	\$3.06	\$3.92	\$6.08	\$10.13	\$12.92	\$13.46	\$13.46	\$8.46	\$6.08
\$20,000	\$1,000	\$0.70	\$1.10	\$1.90	\$3.40	\$4.35	\$6.75	\$11.25	\$14.35	\$14.95	\$14.95	\$9.40	\$6.75
\$22,000	\$1,100	\$0.77	\$1.21	\$2.09	\$3.74	\$4.79	\$7.43	\$12.38	\$15.79	\$16.45	\$16.45	\$10.34	\$7.43
\$24,000	\$1,200	\$0.84	\$1.32	\$2.28	\$4.08	\$5.22	\$8.10	\$13.50	\$17.22	\$17.94	\$17.94	\$11.28	\$8.10
\$26,000	\$1,300	\$0.91	\$1.43	\$2.47	\$4.42	\$5.66	\$8.78	\$14.63	\$18.66	\$19.44	\$19.44	\$12.22	\$8.78
\$28,000	\$1,400	\$0.98	\$1.54	\$2.66	\$4.76	\$6.09	\$9.45	\$15.75	\$20.09	\$20.93	\$20.93	\$13.16	\$9.45
\$30,000	\$1,500	\$1.05	\$1.65	\$2.85	\$5.10	\$6.53	\$10.13	\$16.88	\$21.53	\$22.43	\$22.43	\$14.10	\$10.13
\$32,000	\$1,600	\$1.12	\$1.76	\$3.04	\$5.44	\$6.96	\$10.80	\$18.00	\$22.96	\$23.92	\$23.92	\$15.04	\$10.80
\$34,000	\$1,700	\$1.19	\$1.87	\$3.23	\$5.78	\$7.40	\$11.48	\$19.13	\$24.40	\$25.42	\$25.42	\$15.98	\$11.48
\$36,000	\$1,800	\$1.26	\$1.98	\$3.42	\$6.12	\$7.83	\$12.15	\$20.25	\$25.83	\$26.91	\$26.91	\$16.92	\$12.15
\$38,000	\$1,900	\$1.33	\$2.09	\$3.61	\$6.46	\$8.27	\$12.83	\$21.38	\$27.27	\$28.41	\$28.41	\$17.86	\$12.83
\$40,000	\$2,000	\$1.40	\$2.20	\$3.80	\$6.80	\$8.70	\$13.50	\$22.50	\$28.70	\$29.90	\$29.90	\$18.80	\$13.50
\$42,000	\$2,100	\$1.47	\$2.31	\$3.99	\$7.14	\$9.14	\$14.18	\$23.63	\$30.14	\$31.40	\$31.40	\$19.74	\$14.18
\$44,000	\$2,200	\$1.54	\$2.42	\$4.18	\$7.48	\$9.57	\$14.85	\$24.75	\$31.57	\$32.89	\$32.89	\$20.68	\$14.85
\$46,000	\$2,300	\$1.61	\$2.53	\$4.37	\$7.82	\$10.01	\$15.53	\$25.88	\$33.01	\$34.39	\$34.39	\$21.62	\$15.53
\$48,000	\$2,400	\$1.68	\$2.64	\$4.56	\$8.16	\$10.44	\$16.20	\$27.00	\$34.44	\$35.88	\$35.88	\$22.56	\$16.20

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Voluntary Long-Term Disability Insurance Coverage

One America / Policy # 617892



Voluntary Long-Term Disability Rates

If your annual salary is at least:	You may select a weekly benefit of:	0-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
\$50,000	\$2,500	\$1.75	\$2.75	\$4.75	\$8.50	\$10.88	\$16.88	\$28.13	\$35.88	\$37.38	\$37.38	\$23.50	\$16.88
\$52,000	\$2,600	\$1.82	\$2.86	\$4.94	\$8.84	\$11.31	\$17.55	\$29.25	\$37.31	\$38.87	\$38.87	\$24.44	\$17.55
\$54,000	\$2,700	\$1.89	\$2.97	\$5.13	\$9.18	\$11.75	\$18.23	\$30.38	\$38.75	\$40.37	\$40.37	\$25.38	\$18.23
\$56,000	\$2,800	\$1.96	\$3.08	\$5.32	\$9.52	\$12.18	\$18.90	\$31.50	\$40.18	\$41.86	\$41.86	\$26.32	\$18.90
\$58,000	\$2,900	\$2.03	\$3.19	\$5.51	\$9.86	\$12.62	\$19.58	\$32.63	\$41.62	\$43.36	\$43.36	\$27.26	\$19.58
\$60,000	\$3,000	\$2.10	\$3.30	\$5.70	\$10.20	\$13.05	\$20.25	\$33.75	\$43.05	\$44.85	\$44.85	\$28.20	\$20.25
\$62,000	\$3,100	\$2.17	\$3.41	\$5.89	\$10.54	\$13.49	\$20.93	\$34.88	\$44.49	\$46.35	\$46.35	\$29.14	\$20.93
\$64,000	\$3,200	\$2.24	\$3.52	\$6.08	\$10.88	\$13.92	\$21.60	\$36.00	\$45.92	\$47.84	\$47.84	\$30.08	\$21.60
\$66,000	\$3,300	\$2.31	\$3.63	\$6.27	\$11.22	\$14.36	\$22.28	\$37.13	\$47.36	\$49.34	\$49.34	\$31.02	\$22.28
\$68,000	\$3,400	\$2.38	\$3.74	\$6.46	\$11.56	\$14.79	\$22.95	\$38.25	\$48.79	\$50.83	\$50.83	\$31.96	\$22.95
\$70,000	\$3,500	\$2.45	\$3.85	\$6.65	\$11.90	\$15.23	\$23.63	\$39.38	\$50.23	\$52.33	\$52.33	\$32.90	\$23.63
\$72,000	\$3,600	\$2.52	\$3.96	\$6.84	\$12.24	\$15.66	\$24.30	\$40.50	\$51.66	\$53.82	\$53.82	\$33.84	\$24.30
\$74,000	\$3,700	\$2.59	\$4.07	\$7.03	\$12.58	\$16.10	\$24.98	\$41.63	\$53.10	\$55.32	\$55.32	\$34.78	\$24.98
\$76,000	\$3,800	\$2.66	\$4.18	\$7.22	\$12.92	\$16.53	\$25.65	\$42.75	\$54.53	\$56.81	\$56.81	\$35.72	\$25.65
\$78,000	\$3,900	\$2.73	\$4.29	\$7.41	\$13.26	\$16.97	\$26.33	\$43.88	\$55.97	\$58.31	\$58.31	\$36.66	\$26.33
\$80,000	\$4,000	\$2.80	\$4.40	\$7.60	\$13.60	\$17.40	\$27.00	\$45.00	\$57.40	\$59.80	\$59.80	\$37.60	\$27.00
\$82,000	\$4,100	\$2.87	\$4.51	\$7.79	\$13.94	\$17.84	\$27.68	\$46.13	\$58.84	\$61.30	\$61.30	\$38.54	\$27.68
\$84,000	\$4,200	\$2.94	\$4.62	\$7.98	\$14.28	\$18.27	\$28.35	\$47.25	\$60.27	\$62.79	\$62.79	\$39.48	\$28.35
\$86,000	\$4,300	\$3.01	\$4.73	\$8.17	\$14.62	\$18.71	\$29.03	\$48.38	\$61.71	\$64.29	\$64.29	\$40.42	\$29.03
\$88,000	\$4,400	\$3.08	\$4.84	\$8.36	\$14.96	\$19.14	\$29.70	\$49.50	\$63.14	\$65.78	\$65.78	\$41.36	\$29.70
\$90,000	\$4,500	\$3.15	\$4.95	\$8.55	\$15.30	\$19.58	\$30.38	\$50.63	\$64.58	\$67.28	\$67.28	\$42.30	\$30.38
\$92,000	\$4,600	\$3.22	\$5.06	\$8.74	\$15.64	\$20.01	\$31.05	\$51.75	\$66.01	\$68.77	\$68.77	\$43.24	\$31.05
\$94,000	\$4,700	\$3.29	\$5.17	\$8.93	\$15.98	\$20.45	\$31.73	\$52.88	\$67.45	\$70.27	\$70.27	\$44.18	\$31.73
\$96,000	\$4,800	\$3.36	\$5.28	\$9.12	\$16.32	\$20.88	\$32.40	\$54.00	\$68.88	\$71.76	\$71.76	\$45.12	\$32.40
\$98,000	\$4,900	\$3.43	\$5.39	\$9.31	\$16.66	\$21.32	\$33.08	\$55.13	\$70.32	\$73.26	\$73.26	\$46.06	\$33.08
\$100,000	\$5,000	\$3.50	\$5.50	\$9.50	\$17.00	\$21.75	\$33.75	\$56.25	\$71.75	\$74.75	\$74.75	\$47.00	\$33.75

The following information is a quick overview of the benefits plans currently provided and is not to be interpreted as a complete disclosure of plans entitlement to any of the benefits described. The company reserves the right to adjust, amend and revise benefits plans. In all cases of specific plan interpretations, receipt of benefits or entitlements, the actual plan document shall rule. You can contact your HR department for the actual plan documents.

Online EOI Submission Guide

Policyholder name: Oldham County Fiscal Court

Policyholder number: 00617892-0000-000

Client ID: U455639

Selecting the right amount of insurance is important to ensure you and your loved ones are financially protected. At OneAmerica® our enhanced Evidence of Insurability (EOI) digital solution streamlines the process with a secure step-by-step easy to comprehend application, available 24/7 on any smartphone, tablet or computer.

Login Process

Get started by going to www.oneamerica.com/eoi

- Choose your login type: Employee.
- Fill in your client ID, work email address, first and last name. Hit “Submit”.
- You will receive an email containing your unique link and additional information on accessing the online EOI application.
- Click your unique email link to continue to our secure digital solution.

Application Process

Once your personal identification information is verified, click “Start Now” to begin the process.

- Select your OneAmerica Company Insurance coverage(s).
- Fill in personal demographic information
 - If you are requesting spouse/domestic partner coverage when EOI is required, please fill-in their name and unique email address so they can be prompted to complete the EOI process once you have submitted your application.
- Complete health questions
- Review and sign via DocuSign



Response Process

Receive immediate response.

- If approved, you and your employer will receive a confirmation email.
- If referred, you will receive an email or letter via United States Postal Service (USPS) outlining the additional information needed.
- If declined, you will receive a letter via USPS with more information.

Please visit bit.ly/eoiDigitalSolutionFAQ to view our frequently asked questions, or contact our Employee Benefits Customer Engagement Center at **800-553-5318**.

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When life feels challenging, get caring and confidential help

Your Employee Assistance Program (EAP) offers access to personalized support, resources and no-cost referrals. It's confidential one-on-one help from a master's-level specialist.

No-cost, 24/7 access to support in the moments that matter

EAP helps you and your family with a range of issues, including:

- Identifying resources for managing stress, anxiety and depression
- Offering specialized help in improving relationships at home or work
- Providing guidance on legal and financial concerns
- Finding ways to help you cope with occupational stress and burnout
- Connecting you with care for addressing substance use issues

Call EAP at 1-888-887-4114

- 3 free counseling sessions per incident, per year
- Confidential and private; services will not be shared with your employer



Scan for more info

Use your phone's camera to scan this code and learn more.

The material provided through this program is for informational purposes only. EAP staff cannot diagnose problems or suggest treatment. EAP is not a substitute for your doctor's care. Employees are encouraged to discuss with their doctor how the information provided may be right for them. Your health information is kept confidential in accordance with the law. EAP is not an insurance program and may be discontinued at any time. Due to the potential for a conflict of interest, legal consultation will not be provided on issues that may involve legal action against UnitedHealthcare or its affiliates, or any entity through which the caller is receiving these services directly or indirectly (e.g., employer or health plan). This program and its components may not be available in all states or for all group sizes and is subject to change. Coverage exclusions and limitations may apply.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates.

United Healthcare



Call Your ComPsych® GuidanceResources® program anytime for confidential assistance.

Call: **855.387.9727**

Go online: guidanceresources.com

TDD: 800.697.0353

Your company Web ID: **ONEAMERICA3**

Personal issues, planning for life events or simply managing daily life can affect your work, health and family. Your GuidanceResources program provides support, resources and information for personal and work-life issues. The program is company-sponsored, confidential and provided at no charge to you and your dependents. This flyer explains how GuidanceResources can help you and your family deal with everyday challenges.

Confidential Counseling

3 Session Plan

This no-cost counseling service helps you address stress, relationship and other personal issues you and your family may face. It is staffed by GuidanceConsultantsSM—highly trained master’s and doctoral level clinicians who will listen to your concerns and quickly refer you to in-person counseling (up to 3 sessions per issue per year) and other resources for:

- › Stress, anxiety and depression
- › Relationship/marital conflicts
- › Problems with children
- › Job pressures
- › Grief and loss
- › Substance abuse

Financial Information and Resources

Discover your best options.

Speak by phone with our Certified Public Accountants and Certified Financial Planners on a wide range of financial issues, including:

- › Getting out of debt
- › Credit card or loan problems
- › Tax questions
- › Retirement planning
- › Estate planning
- › Saving for college

Legal Support and Resources

Expert info when you need it.

Talk to our attorneys by phone. If you require representation, we’ll refer you to a qualified attorney in your area for a free 30-minute consultation with a 25% reduction in customary legal fees thereafter.

Call about:

- › Divorce and family law
- › Debt and bankruptcy
- › Landlord/tenant issues
- › Real estate transactions
- › Civil and criminal actions
- › Contracts

Work-Life Solutions

Delegate your “to-do” list.

Our Work-Life specialists will do the research for you, providing qualified referrals and customized resources for:

- › Child and elder care
- › Moving and relocation
- › Making major purchases
- › College planning
- › Pet care
- › Home repair

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GuidanceResources Online is your one stop for expert information on the issues that matter most to you...relationships, work, school, children, wellness, legal, financial, free time and more.

- › Timely articles, HelpSheetsSM, tutorials, streaming videos and self-assessments
- › “Ask the Expert” personal responses to your questions
- › Child care, elder care, attorney and financial planner searches

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Get peace of mind.

EstateGuidance® lets you quickly and easily write a will on your computer. Just go to www.guidanceresources.com and click on the EstateGuidance link. Follow the prompts to create and download your will at no cost. Online support and instructions for executing and filing your will are included. You can:

- › Name an executor to manage your estate
- › Choose a guardian for your children
- › Specify your wishes for your property
- › Provide funeral and burial instructions



Your ComPsych® GuidanceResources® Program

CALL ANYTIME

Call: **855.387.9727**

TDD: 800.697.0353

Online: guidanceresources.com

Your company Web ID: **ONEAMERICA3**

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Worksite Benefits

One America



Worksite Benefits

**Voluntary Employee Life and
Voluntary Dependent Life**

Voluntary Short Term Disability

Voluntary Long Term Disability

Please make your elections on Employee Navigator.

Worksite Benefits

Colonial Life



Worksite Benefits

Voluntary Accident

Voluntary Critical Illness

Please make your elections on Employee Navigator.

The following information is a quick overview of the benefits plans currently provided and is not to be interpreted as a complete disclosure of plans entitlement to any of the benefits described. The company reserves the right to adjust, amend and revise benefits plans. In all cases of specific plan interpretations, receipt of benefits or entitlements, the actual plan document shall rule. You can contact your HR department for the actual plan documents.

Group Critical Illness Insurance

Plan 2 Full



If you're diagnosed with a covered critical illness or cancer, group critical illness insurance* from Colonial Life can help with your expenses, so you can concentrate on what's most important – your treatment, care and recovery.

*The policy name is Critical Illness and Cancer Group Specified Disease Insurance.

Face amount: \$_____

Critical illness benefit

For the diagnosis of this covered critical illness condition: ¹	This percentage of the face amount is payable:
Heart attack (myocardial infarction)	100%
Stroke	100%
End-stage renal (kidney) failure	100%
Major organ failure	100%
Coma	100%
Permanent paralysis due to a covered accident	100%
Blindness	100%
Occupational infectious HIV or occupational infectious hepatitis B, C or D	100%
Coronary artery bypass graft surgery/disease ²	25%

For more information,
talk with your
benefits counselor.

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Subsequent diagnosis of a different critical illness³

If you receive a benefit for a critical illness, and later you are diagnosed with a different critical illness, the original percentage of the face amount is payable for that particular critical illness.

Subsequent diagnosis of the same critical illness³

If you receive a benefit for a critical illness, and later you are diagnosed with the same critical illness, 25% of the original face amount is payable. Critical illness conditions that do not qualify are: coronary artery bypass graft surgery/coronary artery disease² and occupational infectious HIV or occupational infectious hepatitis B, C or D.

Diagnosis of cancer benefit

Covered cancer benefits	
For this condition: ¹	The amount payable is:
Diagnosis of cancer (internal or invasive)	100% of the face amount
Diagnosis of carcinoma in situ	25% of the face amount
Skin cancer	\$500

Cancer vaccine benefit: \$50

This benefit is payable if you or your covered family members incur a charge for any FDA-approved cancer vaccine while your certificate is in force.

1 Please refer to the certificate for complete definitions of covered conditions.

2 Benefit for coronary artery disease applicable in lieu of benefit for coronary artery bypass graft surgery when health savings account (HSA) compliant plan is selected.

3 Dates of diagnoses of a covered critical illness must be separated by at least 180 days.

THIS POLICY PROVIDES LIMITED BENEFITS.

Insureds in MA must be covered by comprehensive health insurance before applying for this coverage.

EXCLUSIONS AND LIMITATIONS FOR CRITICAL ILLNESS

We will not pay the Critical Illness Benefit or Benefit Payable Upon Subsequent Diagnosis of a Critical Illness that occurs as a result of a covered person's: alcoholism or drug addiction; felonies or illegal occupations; intoxicants and narcotics; psychiatric or psychological conditions; suicide or injuries which any covered person intentionally does to himself; war or armed conflict; or pre-existing condition, unless the covered person has satisfied the pre-existing condition limitation period shown on the Certificate Schedule on the date the covered person is diagnosed with a critical illness.

EXCLUSIONS AND LIMITATIONS FOR CANCER

We will not pay the Diagnosis of Cancer Benefit, Diagnosis of Carcinoma in Situ Benefit, the Cancer Treatment and Care Benefit or the Skin Cancer Benefit for a covered person's cancer (internal or invasive), carcinoma in situ or skin cancer that: is diagnosed or treated outside the territorial limits of the United States, its possessions, or the countries of Canada and Mexico; is a pre-existing condition, unless the covered person has satisfied the pre-existing condition limitation period shown on the Certificate Schedule on the date the covered person is initially diagnosed as having cancer (internal or invasive), carcinoma in situ or skin cancer. No pre-existing condition limitation will be applied for dependent children who are born or adopted while you are covered under the policy, and who are continuously covered from the date of birth or adoption.

This is not an insurance contract and only the actual certificate provisions will control. Applicable to certificate form GCC1.0-C (including state abbreviations where used, for example: GCC1.0-C-TX). The certificate or its provisions may vary or be unavailable in some states. Please see your Colonial Life benefits counselor for details.

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Critical Illness Insurance

Health Screening Benefit



The optional health screening benefit can help you reduce the risk of serious illness through early detection.

Health screening benefit..... \$100.00

Maximum of one screening test per covered person per calendar year.

- Blood test for triglycerides
- Bone marrow testing
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- Carotid Doppler
- CEA (blood test for colon cancer)
- Chest X-ray
- Colonoscopy
- Echocardiogram (ECHO)
- Electrocardiogram (EKG, ECG)
- Fasting blood glucose test
- Flexible sigmoidoscopy
- Hemoccult stool analysis
- Mammography
- Pap smear
- PSA (blood test for prostate cancer)
- Serum cholesterol test for HDL and LDL levels
- Serum protein electrophoresis (blood test for myeloma)
- Skin cancer biopsy
- Stress test on a bicycle or treadmill
- Thermography
- ThinPrep pap test
- Virtual colonoscopy

For more information,
talk with your
benefits counselor.

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For cost and complete details, see your Colonial Life benefits counselor. Applicable to form CI-1.0-P and GCC1.0-P (including state abbreviations where used, for example: CI-1.0-P-TX and GCC1.0-P-TX). Coverage may vary by state and may not be available in all states.

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Group Accident Insurance

Preferred Plan



For more information,
talk with your
benefits counselor.

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Group accident insurance can help with medical or other costs associated with a covered accident or injury that your health insurance may not cover. With this coverage you may not need to use your savings or secure a loan to help pay those unexpected out-of-pocket expenses. Coverage options are available for you, your spouse and eligible dependent children.

Benefits are per covered person per covered accident unless stated otherwise

Accident emergency treatment \$150

One visit per covered person per covered accident and
Up to four visits per covered person per calendar year

Accident follow-up doctor visit \$50

Up to four visits per covered person per covered accident and
Up to 16 visits per covered person per calendar year

Accidental death

Per covered person

	Accidental death	Accidental death common carrier
■ Named insured	\$50,000	\$200,000
■ Spouse	\$50,000	\$200,000
■ Dependent child(ren)	\$10,000	\$40,000

Examples of common carriers are mass transit trains, buses and planes

Accidental dismemberment

Loss or loss of use

■ One hand, arm, foot, leg or sight of an eye	\$9,000
■ Both hands, arms, feet, legs or the sight of both eyes; or any combination	\$18,000
■ One finger or one toe	\$1,050
■ Two or more fingers; two or more toes; or any combination	\$2,100

Air ambulance \$1,500

Transportation to or from a hospital or medical facility

Ambulance (ground)..... \$300

Transportation to or from a hospital or medical facility

Appliance aid in personal locomotion or mobility \$100

Walking boot, neck brace, back brace, leg brace, cane, crutches, walker and wheelchair

Blood/plasma/platelets \$400

Required during treatment of a covered accident

Burn

■ 2nd-degree burns (covering at least 36% of the body's surface)	\$1,000
■ 3rd-degree burns (based on size)	\$2,000 – \$15,000

Burn-skin graft..... 50% of applicable burn benefit

As a result of 2nd-degree or 3rd-degree burns

Alex was cleaning out the gutters when he fell.



EMERGENCY ROOM VISIT

Alex was taken by ambulance to the nearest emergency room and received immediate care.



DIAGNOSTIC PROCEDURE

The doctor ordered an X-ray and discovered Alex had fractured his leg.



HOSPITAL CONFINEMENT

Alex was admitted to the hospital for surgery on his leg. He was confined for three days.



APPLIANCE FOR MOBILITY

Alex used crutches.



PHYSICAL THERAPY

Alex had eight sessions of PT to help him regain the strength in his leg.



DOCTOR'S OFFICE VISIT

Over the next several weeks, he had three follow-up appointments with his doctor.

ALEX'S OUT-OF-POCKET EXPENSES

When Alex totaled up the bills, he had to pay his annual deductible, as well as co-payments for the ambulance, emergency room, hospital, surgery, physical therapy and follow-up visits. Luckily, Alex had accident coverage to help with these expenses.

ALEX'S BENEFITS	
Ambulance	\$300
Emergency room visit	\$150
X-ray	\$60
Hospital admission	\$1,000
Hospital confinement	\$750
Leg fracture (surgical)	\$3,600
Physical therapy	\$360
Appliance (crutches)	\$100
Doctor's follow-up office visit	\$150
	\$6,470

Catastrophic accident

Total and irrecoverable loss or loss of use

- Both hands, arms, feet, legs or the sight of both eyes; or any combination; or
- Loss of hearing in both ears or loss of ability to speak

Subject to a 365-day elimination period; payable once per lifetime per covered person

- Named insured\$50,000
- Spouse\$50,000
- Dependent child(ren).....\$25,000

Coma \$10,000

Lasting for 14 or more consecutive days

Concussion \$375

Dislocation (separated joint) Non-surgical Surgical

- Hip\$3,000 \$6,000
- Knee (except patella)\$1,500 \$3,000
- Ankle, bone or bones of the foot (other than toes)\$1,200 \$2,400
- Collarbone (sternoclavicular)\$800 \$1,600
- Collarbone (acromioclavicular and separation)\$200 \$400
- Lower jaw\$720 \$1,440
- Shoulder (glenohumeral)\$1,200 \$2,400
- Elbow\$450 \$900
- Wrist\$600 \$1,200
- Bone(s) of the hand, (other than fingers)\$810 \$1,620
- Finger, toe\$200 \$400
- Incomplete dislocation or dislocation reduction without anesthesia25% of the applicable non-surgical amount

Emergency dental work

- Dental crown or denture\$300
- Dental extraction\$100

Eye injury \$300

With surgical repair or removal of a foreign object

Fracture (broken bone) Non-surgical Surgical

- Skull, depressed fracture (except face/nose)\$3,750 \$7,500
- Skull, simple non-depressed fracture (except face/nose)\$1,800 \$3,600
- Hip, thigh (femur)\$3,150 \$6,300
- Body of vertebrae (excluding vertebral processes)\$2,700 \$5,400
- Pelvis\$2,400 \$4,800
- Leg (tibia and/or fibula)\$1,800 \$3,600
- Bones of the face or nose (except mandible or maxilla)\$910 \$1,820
- Upper jaw, maxilla, upper arm between elbow and shoulder\$1,050 \$2,100
- Lower jaw, mandible\$1,200 \$2,400
- Kneecap, ankle, foot\$1,200 \$2,400
- Shoulder blade, collarbone\$1,200 \$2,400
- Vertebral processes\$630 \$1,260
- Forearm, hand, wrist\$1,200 \$2,400
- Rib\$375 \$750
- Coccyx\$320 \$640
- Finger, toe\$200 \$400
- Chip fracture25% of the applicable non-surgical amount

For illustrative purposes only.

Benefit amounts may vary and may not cover all expenses. The certificate has exclusions and limitations.

Hospital admission	\$1,000
Per covered person per covered accident	
Hospital confinement	\$250 per day
Up to 365 days per covered person per covered accident	
Hospital intensive care unit admission	\$1,750
Per covered person per covered accident	
Hospital intensive care unit confinement	\$400 per day
Up to 15 days per covered person per covered accident	
Knee cartilage (torn)	\$750
Laceration (no repair, without stitches)	\$50
Laceration (repaired by stitches)	
■ Total of all lacerations is less than two inches long	\$150
■ Total of all lacerations is at least two but less than six inches long	\$300
■ Total of all lacerations is six inches or longer	\$600
Lodging (companion)	\$200 per day
Up to 30 days per covered person per covered accident	
Medical imaging study (CT, CAT scan, EEG, MR or MRI)	\$200
One benefit per covered person per covered accident per calendar year	
Occupational or physical therapy	\$45 per day
Up to 10 days per covered person per covered accident	
Pain management for epidural anesthesia	\$150
Prosthetic device/artificial limb	
One benefit per covered person per covered accident	
■ One	\$1,250
■ More than one	\$2,500
Rehabilitation unit confinement	\$150 per day
Immediately after a period of hospital confinement due to a covered accident; up to 15 days per covered person per covered accident, not to exceed 30 days per covered person per calendar year	
Ruptured disc with surgical repair	\$900
Surgery	
■ Cranial, open abdominal and thoracic	\$1,500
■ Hernia with surgical repair	\$300
Surgery (exploratory and arthroscopic)	\$225
Tendon/ligament/rotator cuff	
■ One with surgical repair	\$900
■ Two or more with surgical repair	\$1,800
Transportation for hospital confinement	\$600 per round trip
Up to three round trips for more than 50 miles from home per covered person per covered accident	
X-ray	\$60



For more information,
talk with your
benefits counselor.

Group Accident Insurance

Health Screening Benefit



This benefit can help pay for routine preventive tests and services.

Health screening **\$50.00**

Payable once per covered person per calendar year; subject to a 30-day waiting period

- Blood test for triglycerides
- Bone marrow testing
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- Carotid Doppler
- CEA (blood test for colon cancer)
- Chest X-ray
- Colonoscopy
- Echocardiogram (ECHO)
- Electrocardiogram (EKG, ECG)
- Fasting blood glucose test
- Flexible sigmoidoscopy
- Hemoccult stool analysis
- Mammography
- Pap smear
- PSA (blood test for prostate cancer)
- Serum cholesterol test for HDL and LDL levels
- Serum protein electrophoresis (blood test for myeloma)
- Skin cancer biopsy
- Stress test on a bicycle or treadmill
- Thermography
- ThinPrep pap test
- Virtual colonoscopy

For more information,
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benefits counselor.

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HEALTH SAVINGS ACCOUNT (HSA) COMPATIBLE

This plan is compatible with HSA guidelines and any other HSA plan in which a covered family member may participate. It may also be offered to employees who do not have HSAs.

The covered person must incur a charge and the certificate must be in force for benefits to be payable.

This information is not intended to be a complete description of the insurance coverage available. For cost and complete details, see your Colonial Life benefits counselor. This brochure is applicable to policy form GACC1.0-P and certificate form GACC1.0-C (plus state abbreviations where applicable, such as GACC1.0-C-TX). Coverage may vary by state and may not be available in all states. Premium at the effective date will vary according to family coverage type and benefit amount selected.

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Group Critical Care for KY

Applicable to policy forms GCC1.0-P & GCC1.0-C

- Full CI Benefit, with Subsequent Diagnosis, Diagnosis of Cancer Benefit, \$100 Health Screening Benefit, HSA Compliant

Non-Tobacco Rates

	ISSUE AGE	NAMED INSURED	EMPLOYEE & SPOUSE	ONE-PARENT FAMILY	TWO-PARENT FAMILY
\$5,000	16-29	\$4.23	\$6.53	\$4.38	\$6.68
	30-39	\$5.18	\$7.93	\$5.31	\$8.06
	40-49	\$7.23	\$11.03	\$7.38	\$11.18
	50-59	\$10.61	\$16.31	\$10.76	\$16.46
	60-74	\$15.23	\$23.36	\$15.41	\$23.51
\$10,000	16-29	\$5.13	\$7.88	\$5.43	\$8.18
	30-39	\$7.03	\$10.68	\$7.28	\$10.93
	40-49	\$11.13	\$16.88	\$11.43	\$17.18
	50-59	\$17.88	\$27.43	\$18.18	\$27.73
	60-74	\$27.13	\$41.53	\$27.48	\$41.83
\$20,000	16-29	\$6.93	\$10.58	\$7.53	\$11.18
	30-39	\$10.73	\$16.18	\$11.23	\$16.68
	40-49	\$18.93	\$28.58	\$19.53	\$29.18
	50-59	\$32.43	\$49.68	\$33.03	\$50.28
	60-74	\$50.93	\$77.88	\$51.63	\$78.48
\$30,000	16-29	\$8.73	\$13.28	\$9.63	\$14.18
	30-39	\$14.43	\$21.68	\$15.18	\$22.43
	40-49	\$26.73	\$40.28	\$27.63	\$41.18
	50-59	\$46.98	\$71.93	\$47.88	\$72.83
	60-74	\$74.73	\$114.23	\$75.78	\$115.13

Tobacco Rates

	ISSUE AGE	NAMED INSURED	EMPLOYEE & SPOUSE	ONE-PARENT FAMILY	TWO-PARENT FAMILY
\$5,000	16-29	\$4.81	\$7.38	\$4.93	\$7.51
	30-39	\$6.21	\$9.46	\$6.33	\$9.58
	40-49	\$9.61	\$14.58	\$9.76	\$14.73
	50-59	\$15.11	\$23.26	\$15.26	\$23.41
	60-74	\$22.98	\$35.28	\$23.16	\$35.46
\$10,000	16-29	\$6.28	\$9.58	\$6.53	\$9.83
	30-39	\$9.08	\$13.73	\$9.33	\$13.98
	40-49	\$15.88	\$23.98	\$16.18	\$24.28
	50-59	\$26.88	\$41.33	\$27.18	\$41.63
	60-74	\$42.63	\$65.38	\$42.98	\$65.73
\$20,000	16-29	\$9.23	\$13.98	\$9.73	\$14.48
	30-39	\$14.83	\$22.28	\$15.33	\$22.78
	40-49	\$28.43	\$42.78	\$29.03	\$43.38
	50-59	\$50.43	\$77.48	\$51.03	\$78.08
	60-74	\$81.93	\$125.58	\$82.63	\$126.28

(Continued...)

Group Critical Care for KY

Applicable to policy forms GCC1.0-P & GCC1.0-C

- Full CI Benefit, with Subsequent Diagnosis, Diagnosis of Cancer Benefit, \$100 Health Screening Benefit, HSA Compliant

Tobacco Rates

	ISSUE AGE	NAMED INSURED	EMPLOYEE & SPOUSE	ONE-PARENT FAMILY	TWO-PARENT FAMILY
\$30,000	16-29	\$12.18	\$18.38	\$12.93	\$19.13
	30-39	\$20.58	\$30.83	\$21.33	\$31.58
	40-49	\$40.98	\$61.58	\$41.88	\$62.48
	50-59	\$73.98	\$113.63	\$74.88	\$114.53
	60-74	\$121.23	\$185.78	\$122.28	\$186.83

Group Accident for KY

Applicable to policy forms GACC1.0-P & GACC1.0-C

- Off-Job Accident Coverage, Health Screening Benefit (\$50 Benefit)

Preferred

ISSUE AGE	NAMED INSURED	EMPLOYEE & SPOUSE	ONE-PARENT FAMILY	TWO-PARENT FAMILY
17-99	\$6.70	\$10.92	\$11.83	\$16.05

Important Notice

Insurance coverage has exclusions and limitations that may affect benefits payable. For a complete description of benefits, limitations and exclusions, please refer to an outline of coverage, sample policy/certificate, proposal description or see your Colonial Life benefits counselor. Coverage type, benefits and rates vary by state. Coverage may not be available in all states. Rates provided are illustrative and your actual premium may be different depending on your particular situation and plan choices.

Colonial Life products are underwritten by Colonial Life & Accident Insurance Company, for which Colonial Life is the marketing brand.

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Underwritten by Colonial Life & Accident Insurance Company

How to File a Health Screening Benefit/Wellness Claim

Colonial Life



How to File a Health Screening Benefit/Wellness Claim:

What you will need before making the phone call or going online to www.coloniallife.com:

1. Date the test was performed
2. Type of test performed
3. Bank Information for direct deposit (if filing online)



For test performed in the last 36 months - Call or file online

Instructions To File by Phone

- Call **1-800-325-4368**
- At the beginning of the call, don't say anything when prompted to. The system will redirect you and then follow the prompts below.
- Follow the prompts to "File a Claim over the phone" #2 then "Wellness" #1 and then "Wellness Claim" #1
- Enter your Social Security #.
- Listen and enter your information when prompted to.

Instructions To File Online

- Go to www.coloniallife.com
- You will need to Register as a Policyholder if you have not already done so.
- Use your Username and Password to log in to file a claim.
- You can have your check deposited directly into your bank account.

For test performed over 36 months

You will need to obtain an itemized statement from your Doctor that shows the procedure code for the type of test performed and the date of service. You can FAX the statement to 1-800-880-9325.

Make sure that you have your Social Security number written on the statement and write **WELLNESS BENEFIT** on the statement so the claim can be processed quickly.

If you are enrolling for the first time in a Colonial Life product or adding a new product, there is a 30 day waiting period to make your first Wellness Claim.



ANY QUESTIONS

Please call or email :

Amy Farnsley

(502) 640-1778

amy.farnsley@coloniallifesales.com

Single Sign-On

Quick Reference Guide



Introducing seamless connectivity with Single Sign-On

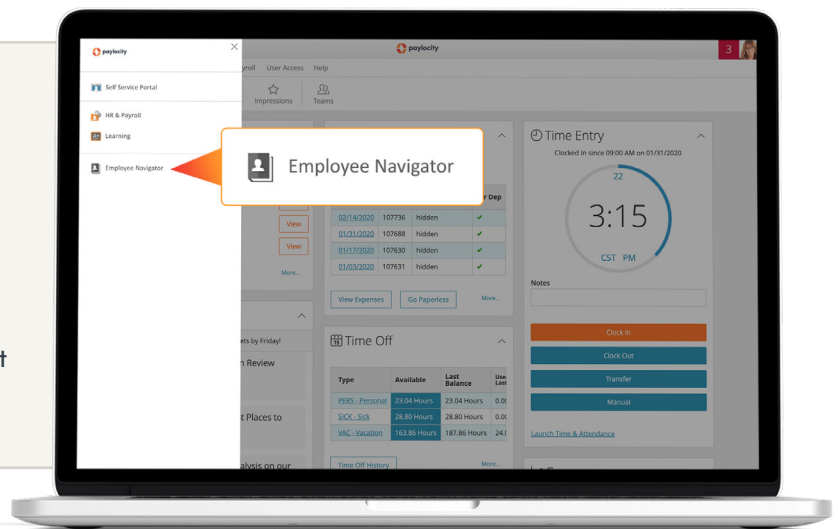
Single Sign-On (SSO) capability is an added feature for the Paylocity and Employee Navigator payroll integration.

This SSO functionality allows employees to seamlessly log into Employee Navigator without a username or password when they access the SSO link within their Paylocity self-service portal.

To access the Single Sign-On link:

- Employees login to their Paylocity self-service portal
- Navigate to the menu on the upper left-hand side of their Paylocity account
- Click on the "Employee Navigator" link

Note: First time users will be asked to accept a one-time Terms and Conditions page.



Questions?

Email us at eenavsupport@paylocity.com

Carrier Contact Information



Benefit	Carrier	Phone Number	Carrier Website
Medical Insurance	United Healthcare	1-888-350-5616 For Mental Health: 1-800-468-2111	www.myuhc.com
Health Savings Account (HSA)	Optum Financial	1-866-234-8913	optumbank.com
Health Reimbursement Account (HRA)	McGregor & Associates	1-859-233-4377	www.mcgregoreba.com
Dental Insurance	Humana	1-866-427-7478	www.humana.com
Vision Insurance	Humana	1-877-398-2980	www.humana.com
Basic/AD&D and Voluntary Life Insurance	One America	1-800-553-5318	www.oneamerica.com
Voluntary Short and Long Term Disability Insurance	One America	1-800-553-5318	www.oneamerica.com
Employee Assistance Program (EAP)	Compsych	1-855-387-9727	www.guidanceresources.com
Employee Assistance Program (EAP)	United Healthcare	1-888-887-4114	www.myuhc.com
Additional Voluntary Benefits	Colonial Life Amy Farnsley	1-800-325-4368 1-502-640-1778	www.coloniallife.com

The Foundation Risk Partners Team is a part of your team

Your contacts for employee benefits questions include:

Your Main Contact



Sherry Tracy

Sr. Account Manager

STracy@FoudationRP.com

502.493.7966

Your account manager is here to:

- Be your day-to-day contact
- Assist with claims and enrollment
- Answer questions about eligibility and billing

Additional Contacts



June Lanham

Sr. Account Executive

JLanham@FoundationRP.com

502.371.4035



Kristen Klimchak, MPH

Wellness Consultant

KKlimchak@FoundationRP.com

502.493.7951

Additional Insurance Services

Insurance can be confusing and stressful. Don't let that keep you from having the appropriate coverage for your family & belongings. Let us help take the stress out of it for you. Our staff is equipped with the tools and knowledge to ensure you have the right coverage options. **Call our main number below or ask your account manager for more information.**



Personal Home & Auto



Medicare Solutions

Your Medicare Solutions

Whether you are retiring at 65 or older, Malloy Advisors can help put the pieces of your Medicare coverage together.

Medicare can be confusing and puzzling. Relax and know that you have skilled, professional advisors on your side at no cost or obligation.

- Am I required to enroll if I'm still working?
- When am I eligible?
- What if I miss my initial enrollment period?
- How do I enroll?

Staffed by certified and licensed advisors, Malloy Advisors take a consultative approach that provides clarity so that you and your loved ones make choices that meet your healthcare needs.

Contact us to schedule a personal one on one consultation.

Scan QR Code to View our Website
800-933-8129
answers@malloymedicare.com
670 Exton Commons
Exton, PA 19341



Malloy Advisors
Solving the Medicare PuzzleSM

Exchange Notice



Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%¹ (9.96% adjusted for 2026) of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.¹²

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15. Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.

Marketplace-eligible individuals who live in states served by HealthCare.gov and either-submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit <https://www.healthcare.gov/medicaid-chip/gettingmedicaid-chip/> for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact [Tina Schaaf](#).

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

¹Indexed annually; see <https://www.irs.gov/pub/irs-drop/rp-22-34.pdf> for 2023

²An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient and hospital services and physician services.

Exchange Notice, continued



Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Oldham County Fiscal Court		4. Employer Identification Number (EIN) 61-6013124	
5. Employer address 100 W Jefferson Street		6. Employer phone number 502-222-9357	
7. City LaGrange	8. State KY	9. Zip code 40031	
10. Who can we contact about employee health coverage at this job? Tina Schaaf			
11. Phone number (if different from above) 502-222-9357		12. Email address tschaaf@oldhamcountky.gov	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

All employees. Eligible employees are:

Some employees. Eligible employees are:

Any employee who works 30 hours or more per week

- With respect to dependents:

We do offer coverage. Eligible dependents are:

Spouse and dependent children

We do not offer coverage.

If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months? <input type="checkbox"/> Yes (Continue) 13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage _____ (mm/dd/yyyy) (Continue) <input type="checkbox"/> No (STOP and return this form to the employee)
14. Does the employer offer a health plan that meets the minimum value standard*? <input type="checkbox"/> Yes (Go to question 15) <input type="checkbox"/> No (STOP and return form to employee)
15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs. 15a. How much would the employee have to pay in premiums for this plan? \$ _____ 15b. How often <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year? _____ <input type="checkbox"/> Employer won't offer health coverage <input type="checkbox"/> Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.) 16a. How much would the employee have to pay in premiums for this plan? \$ _____ 16b. How often? <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Yearly

If you believe you are eligible and decide to shop for coverage in the Marketplace, please refer to your employer.

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

This information is an abbreviation of the compliance notices currently in place by the Department of Labor and should not be interpreted as a complete disclosure of notices. Contact your HR department for questions pertaining to any notices.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)



If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility –

INDIANA - Medicaid	KENTUCKY - Medicaid
Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ https://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone 1-800-403-0864 Member Services Phone: 1-800-457-4584	Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

Federal Requirement Notices



Newborns' and Mothers' Health Protection Act of 1996 (Newborn's Act)

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

The Women's Health and Cancer Rights Act of 1998 (WHCRA, also known as Janet's Law)

Under WHCRA, group health plans, insurance companies and health maintenance organizations (HMOs) offering mastectomy coverage must also provide coverage for reconstructive surgery in a manner determined in consultation with the attending physician and the patient. Coverage includes reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas. Call your Plan Administrator for more information.

Qualified Medical Support Order (QMCSO)

QMCSO is a medical child support order issued under State law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An "alternate recipient" is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer on the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

Special Enrollment Rights (HIPAA)

If you have previously declined enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Special Enrollment Rights CHIPRA - Children's Health Insurance Plan

You and your dependents who are eligible for coverage, but who have not enrolled, have the right to elect coverage during the plan year under two circumstances: You or your dependent's state Medicaid or CHIP (Children's Health Insurance Program) coverage terminated because you ceased to be eligible. You become eligible for a CHIP premium assistant subsidy under state Medicaid or CHIP (Children's Health Insurance Program). You must request special enrollment within 60 days of the loss of coverage and/or within 60 days of when eligibility is determined for the premium subsidy.

Coverage Extension Rights under the Uniformed Services Employment and Reemployment Rights Act (USERRA)

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 (including spouse) for up to 24 months while in the military. Even if you do not 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 for pre-existing conditions except for service-connected injuries or illnesses.

Michelle's Law

Michelle's Law permits seriously ill or injured college students to continue coverage under a group health plan when they must leave school on a full-time basis due to their injury or illness and would otherwise lose coverage. The continuation of coverage applies to a dependent child's leave of absence from (or other change in enrollment) a postsecondary educational institution (college or university) because of a serious illness or injury, while covered under a health plan. This would otherwise cause the child to lose dependent status under the terms of the plan. Coverage will be continued until:

1. One year from the start of the medically necessary leave of absence, or
2. The date on which the coverage would otherwise terminate under the terms of the health plan; whichever is earlier.

Mental Health Parity and Addiction Equity Act of 2008

This act expands the mental health parity requirements in the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Services Act by imposing new mandates on group health plans that provide both medical and surgical benefits and mental health or substance abuse disorder benefits. Among the new requirements, such plans (or the health insurance coverage offered in connection with such plans) must ensure that: The financial requirements applicable to mental health or substance abuse disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance abuse disorder benefits.

Genetic Information Non-Discrimination Act (GINA)

GINA broadly prohibits covered employers from discriminating against an employee, individual, or member because of the employee's "genetic information," which is broadly defined in GINA to mean (1) genetic tests of the individual, (2) genetic tests of family members of the individual, and (3) the manifestation of a disease or disorder in family members of such individual. GINA also prohibits employers from requesting, requiring, or purchasing an employee's genetic information. This prohibition does not extend to information that is requested or required to comply with the certification requirements of family and medical leave laws, or to information inadvertently obtained through lawful inquiries under, for example, the Americans with Disabilities Act, provided the employer does not use the information in any discriminatory manner. In the event a covered employer lawfully (or inadvertently) acquires genetic information, the information must be kept in a separate file and treated as a confidential medical record and may be disclosed to third parties only in very limited situations.

No Surprises Act

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"**Out-of-network**" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays, and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"**Surprise billing**" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed. If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections. You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
 - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
 - Cover emergency services by out-of-network providers.
 - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
 - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

This information is an abbreviation of the compliance notices currently in place by the Department of Labor and should not be interpreted as a complete disclosure of notices. Contact your HR department for questions pertaining to any notices.

Federal Requirement Notices



Important Notice from Oldham County Fiscal Court About Your Creditable Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Oldham County Fiscal Court and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Oldham County Fiscal Court has determined that the prescription drug coverage offered by the United EHDHP is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents will not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Oldham County Fiscal Court and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the Entity/Sender listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Oldham County Fiscal Court changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: 01/01/2026

Name of Entity/Sender: Oldham County Fiscal Court

CMS Form 10182-CC

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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2026 Annual Privacy Notice

United Healthcare “UHC Rewards” is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you may be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease).

You are not required to participate in the wellness program. However, employees who choose to participate in the wellness program will receive an incentive of up to \$1,000.00 for completing certain health-related activities like utilizing a compatible activity tracker and hitting daily step goals.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Tina Schaaf at tschaaf@oldhamcountyky.gov.

The information from your HRA may be used to provide you with information to help you understand your current health and potential risks and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Oldham County Fiscal Court may use aggregate information it collects to design a program based on identified health risks in the workplace, United Healthcare “UHC Rewards” will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. Personally identifiable health information (PII) that you provide in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate. If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Tina Schaaf at tschaaf@oldhamcountyky.gov.

Notice of Privacy Practices



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

The Plan is required to provide this Notice to you by the privacy rules (the "Privacy Rules") issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The Notice describes the practices of the group health plan components of the Oldham County Fiscal Court's Group Benefit Plan (the "Plan") which is a hybrid entity. The Plan can revise this Notice at any time. If the Plan makes any material change to this Notice, you will be provided with a revised Notice. If you have any questions, please contact: Tina Schaaf.

Your Protected Health Information - The Privacy Rules only protect certain medical information, which is known as "protected health information" (or "PHI"). Generally, PHI is individually identifiable health information created or received in connection with the Plan that relates to: (1) your past, present or future physical or mental health; (2) providing you with health care; or (3) the past, present or future payment for your care. This Notice only applies to the Plan's PHI.

Our Pledge Regarding Medical Information - The Plan understands that medical information about you and your health is personal. The Plan is committed to protecting medical information about you. A record of the health care claims reimbursed under the Plan is created for purposes of the administration of the Plan. This notice applies to all of the medical records maintained by the Plan. Your personal doctor or health care provider may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic.

This notice will tell you about the ways in which your medical information may be used or disclosed. It also describes the Plan's obligations and your rights regarding the use and disclosure of medical information.

The Plan is required by law to make sure that medical information that identifies you is kept private; give you this notice of the Plan's legal duties and privacy practices with respect to medical information about you; and follow the terms of this notice.

The Plan's Use and Disclosure of PHI - In certain circumstances, the Plan can use or disclose your PHI without your permission. However, most uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI, require an authorization. The following categories describe the different ways that your PHI can be used.

For Payment. The Plan can use or disclose your PHI in connection with: (1) determining your eligibility benefits; (2) facilitating payment for treatment and services that you received from health care providers; (3) determining the Plan's benefit responsibility; and (4) coordinating coverage. For example, the Plan may tell your health care provider about your medical history so he or she can determine whether a treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. The Plan can also disclose your PHI to a utilization review provider, precertification provider, or to another entity (or health plan) to assist with the adjudication, subrogation or coordination of payment for health claims.

For Health Care Operations. The Plan can use or disclose your PHI in connection with other operations that are necessary to run the Plan. For example, PHI may be used in connection with: (1) quality assessment and improvement activities; (2) underwriting, premium rating and other similar activities (however, genetic information cannot be used or disclosed for underwriting purposes); (3) submitting stop-loss (or excess loss) claims; (4) conducting medical review, legal services, audit services, and fraud and abuse detection; (4) business planning, management, and development; and (5) the Plan's general administrative activities.

For Treatment. The Plan can use or disclose your PHI to facilitate medical treatment or services by health care providers, including doctors, nurses, technicians, medical students, or other medical personnel who are taking care of you. For example, information about your prior prescriptions can be disclosed to a pharmacist to determine if a pending prescription is contraindicative with prior prescriptions.

To Business Associates. The Plan can contract with individuals or entities known as "Business Associates" to perform various functions or services on its behalf. To perform these functions or services, a Business Associate will have access to, and may use and disclose, your PHI, but only after they enter into an agreement with the Plan to implement appropriate safeguards intended to protect your PHI (i.e., a "Business Associate Agreement"). For example, after entering into a Business Associate Agreement the Plan may disclose your PHI to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation.

As Required by Law. The Plan can disclose your PHI when it is required by federal, state or local law. For example, the Plan can disclose your PHI when required to do so by federal or public health disclosure laws.

To Avert a Serious Threat to Health or Safety. The Plan can use or disclose your PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. However, disclosures can only be made to those able to help prevent the threat.

To the Company. For the purposes of administering the Plan, your PHI may be disclosed to certain employees who will generally only use or disclose your PHI to perform administration functions for the Plan or as required by the Privacy Rules. Your PHI cannot be used for employment purposes without your authorization.

More Stringent State Laws. In certain situations, the Plan may be required to comply with state laws that have requirements that are more stringent than those described in this Notice.

Special Situations

Organ and Tissue Donation. If you are an organ donor, the Plan can disclose your PHI to organizations that handle organ procurement or organ, eye or tissue transplantation, or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the U.S., armed forces or a foreign military, the Plan may disclose your PHI as required by military authorities.

Workers' Compensation. The Plan can disclose your PHI in connection with workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Public Health Risks. The Plan can disclose your PHI for public health activities, such as those which involve: (1) preventing or controlling disease, injury or disability; (2) reporting births and deaths; (3) reporting child abuse or neglect; (4) reporting reactions to medications or problems with products; (5) notifying people of recalls of products; (6) notifying people who may have been exposed to a disease or may be at risk for contracting or spreading a disease; and (7) notifying the appropriate government authority if it is believed you have been the victim of abuse, neglect or domestic violence, and if you agree to the disclosure or it is required or authorized by law.

Health Oversight Activities. The Plan can disclose your PHI to a health oversight agency for activities, authorized by law, that are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws. These activities include audits, investigations, inspections, and licensure.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, the Plan can disclose your PHI in response to a court or administrative order, subpoena, discovery request, or other lawful process by someone else involved in the dispute. However, efforts must have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. The Plan can disclose your PHI if requested by a law enforcement official: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime if, under certain limited circumstances, the Plan are unable to obtain the victim's authorization; (4) about a death that is believed to be the result of criminal conduct; or (5) about certain criminal conduct.

Coroners, Medical Examiners and Funeral Directors. The Plan can disclose your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. The Plan can also disclose your PHI to a funeral director if necessary to carry out his or her duties.

National Security and Intelligence Activities. The Plan can disclose your PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Plan can disclose your PHI to the correctional institution or law enforcement official if necessary for the institution: (1) to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

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

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Notice of Privacy Practices



Other Disclosures

Legal Representatives. The Plan will generally disclose your PHI to individuals authorized by you, or to your legal representative if you provide the Plan with written notice/authorization and supporting documents (e.g., power of attorney). However, the Plan is not required to disclose your PHI to your legal representative if the Plan reasonably believes that: (1) you have been, or may be, subjected to domestic violence, abuse or neglect by this person, or treating this person as your legal representative could endanger you; and (2) in the Plan's professional judgment, it is not in your best interest to treat this person as your legal representative.

Spouses/Family Members. The Plan will generally send all mail to the employee covered under the Plan, including mail relating to his or her family members covered under the Plan (e.g. use and denial of benefits). If someone covered under the Plan requested restrictions or confidential Communications (described later in this Notice), and if the HIPAA Privacy Officer agreed to the request, the Plan will send mail as provided by the request.

Authorizations. Uses or disclosures of your PHI that are not described in this Notice will only be made with your written authorization. You can revoke a written authorization at any time if the revocation is in writing. Written revocations are only effective for future uses and disclosures and will not be effective for PHI that may have been used or disclosed (in reliance upon your written authorization) prior to receiving your revocation.

Your Rights

Inspecting and Copying PHI. You have the right to inspect and copy certain PHI that may be used to make decisions about your benefits under the Plans. To inspect and copy this PHI, you must submit your request in writing to the HIPAA Privacy Officer. If you request a copy of the information, you may be charged a fee for the costs of copying, mailing or other supplies associated with your request. The Plan can deny your request to inspect and copy PHI in certain limited circumstances. If you are denied access to your PHI, you can request that the denial be reviewed by submitting a request in writing to the HIPAA Privacy Officer.

Amending PHI. If you believe that certain PHI that is maintained by the Plan is incorrect or incomplete, you have the right to request an amendment as long as the PHI is maintained by the Plan. You can request an amendment, by submitting a written request in writing (along with the reason for your request) to the HIPAA Privacy Officer. Your request may be denied if: (1) it is not in writing; (2) it does not include a valid reason to support the request; (3) it requests an amendment to PHI that is not maintained by the Plan, was not created by the Plan (unless the person or entity that created the PHI is no longer available to make the amendment, or is not PHI that you are permitted to inspect and copy; or (4) it requests an amendment to PHI that is accurate and complete. If your request is denied, you can file a statement of disagreement in writing with the HIPAA Privacy Officer, and then any future disclosures of the disputed PHI will include your statement.

Right to an Accounting of Disclosures. You have the right to request an "accounting" of certain disclosures of your PHI. However, an accounting will not include: (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures that you authorized; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures. To request an accounting of disclosures, you must submit your request in writing to the HIPAA Privacy Officer. Your request must provide for a time period for the disclosures of not longer than 6 years and may not request disclosures made more than six years before the date you make your request. Your request must indicate the form in which you would like to receive the disclosures (e.g., paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, you may be charged for the costs of providing the disclosures to you. You will be notified of the cost involved and may choose to withdraw or modify your request at that time before any costs are incurred.

Requesting Restrictions. You have the right to request a restriction on uses and disclosures of your PHI that the Plan normally would use or disclose for treatment, payment, or health care operations, or would disclose to someone involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that the Plan not to disclose PHI about a surgery. The Plan is generally not required to agree to your request. However, if your request is denied, the Plan will honor the restriction until you revoke your request or you are notified of the denial. You must send a written request for restrictions to the HIPAA Privacy Officer. Your request must contain: (1) the PHI you want to limit; (2) whether you want to limit the Plan use, disclosure, or both; and (3) to whom you want the limits to apply (e.g., disclosures should not be made to your spouse).

Requesting Confidential Communications. You have the right to request that the Plan communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that the Plan only contact you at work or by mail. The Plan will accommodate reasonable requests if you provide clear information that the disclosure of all or part of your PHI could endanger you. You must send a written request for confidential communications to the HIPAA Privacy Officer. Your request must specify how or where you wish to be contacted. You will not be asked the reason for your request.

Breach Notification. You have the right to be notified in the event that we (or a Business Associate) discover a breach of your "unsecured" PHI.

Paper Copy of This Notice. You can ask the Plan for a paper copy of this Notice any time.

Complaints. If you believe your privacy rights have been violated, you can file a complaint with the Plan or the Secretary of the Department of Health and Human Services by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201. You will not be penalized for filing a complaint.

Changes to This Notice

The Plan reserves the right to change this notice. The Plan reserves the right to make the revised or changed notice effective for medical information the Plan already has about you, as well as any information the Plan receives in the future. A copy of the current notice will be posted on the website where other information about the Plan is located. The notice will contain on the first page, in the title section, the effective date.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this notice or the laws that apply to the Plan will be made only with your written permission. If you provide permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, the Plan will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that the Plan is unable to take back any disclosures already made with your permission, and that the Plan is required to retain our records of the care that the Plan provided to you.

Conclusion

The use and disclosure of medical information by the Plans is regulated by a federal law known as HIPAA and the Privacy Rules under HIPAA. You may find these rules at 45 Code of Federal Regulations Parts 160 and 164. This notice attempts to summarize the Privacy Rules. The Privacy Rules will supersede any discrepancy between the information in this notice and the Privacy Rules.

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Offices in:

Kentucky | Ohio

502-805-3742

www.FoundationRP.com