This Benefits Guide has been prepared to help you review the key factors that are associated with our benefit plans. This Benefits Guide does not provide all of the contractual provisions, limitations or exclusions included in our policies and should be considered only as a summary of our current benefits. If any differences exist between this summary and the official contracts, the contracts shall prevail.
# 2018 BENEFIT ELECTION and CONSENT FORM

## I AM ENROLLED IN MEDICARE or VETERANS BENEFITS

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Social Security Number</th>
<th>Date of Birth</th>
<th>Date of Hire</th>
<th>Marital Status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Married</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home Address (Street, City, State, Zip Code)</th>
<th>Phone Number:</th>
</tr>
</thead>
</table>

## DEPENDENT INFORMATION

<table>
<thead>
<tr>
<th>Dependent Name</th>
<th>Dependent SSN</th>
<th>Date of Birth</th>
<th>Sex</th>
<th>Relationship</th>
<th>M</th>
<th>D</th>
<th>V</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joe Example</td>
<td>123-45-6789</td>
<td>01/05/1990</td>
<td>M</td>
<td>Spouse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>M / F</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>M / F</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>M / F</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>M / F</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Employee Election - Medical

(choose the box that corresponds to your coverage selection)

### Weekly Deductions

<table>
<thead>
<tr>
<th>United HealthCare</th>
<th>HDHP $2000 PLAN</th>
<th>HDHP $2700 PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Wellness</td>
<td>Non-Wellness</td>
</tr>
<tr>
<td>Employee Only</td>
<td>$35.58</td>
<td>$40.35</td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$80.06</td>
<td>$90.79</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$76.50</td>
<td>$86.76</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$99.63</td>
<td>$112.99</td>
</tr>
</tbody>
</table>

I am not electing medical coverage.  

### I choose to Waive medical coverage.

## Employee Election - Dental

(choose the box that corresponds to your coverage selection)

### Weekly Deductions

<table>
<thead>
<tr>
<th>Dental Care Plus</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$5.94</td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$12.81</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$12.94</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$23.06</td>
</tr>
</tbody>
</table>

I am not electing dental coverage.  

### I choose to Waive dental coverage.

## Employee Election - Vision

(choose the box that corresponds to your coverage selection)

### Weekly Deductions

<table>
<thead>
<tr>
<th>EyeMed</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$1.45</td>
</tr>
<tr>
<td>Employee + Spouse (domestic partner)</td>
<td>$2.90</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$2.76</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$4.26</td>
</tr>
</tbody>
</table>

I am not electing vision coverage.  

### I choose to Waive vision coverage.
**Health Savings Account (HSA) Annual Maximums**

- $3,450 for individual
- $6,850 for family

I would like the following weekly deductions contributed to my HSA:

- maximum $66.34 per week for individual coverage
- maximum $132.69 per week for family coverage

- I would like to contribute an additional $1000 (as a catch-up contribution), as I am over the age of 55. (additional $19.23 per week)

**Flexible Spending Account (FSA) Annual Maximum**

- $2,650 for Healthcare
- $5,000 for Dependent Care

If you are enrolled in Medicare or Veterans Benefits, you cannot contribute to a Health Savings Account, but you can opt to contribute to a Flexible Spending Account.

I would like the following weekly deductions contributed to my FSA:

- Healthcare (maximum $50.96 per week)
- Dependent Care (maximum $96.15 per week)

**Employee Election: Employee Paid Voluntary Life Insurance and AD&D**

(check the box that corresponds to your coverage selection)

**Note:** If you elect Employee Paid Voluntary Life and AD&D coverage for yourself or your spouse in an amount greater than the Guaranteed Issue amount, you must complete an Evidence of Insurability health questionnaire for consideration of the higher coverage amount.

<table>
<thead>
<tr>
<th>Employee Paid Voluntary Life and AD&amp;D</th>
<th>Available in $10,000 increments to a max of $200,000. <strong>Guaranteed Issue:</strong> $100,000</th>
<th>Election Amount $___________</th>
<th>Premium Per Week $__________</th>
</tr>
</thead>
<tbody>
<tr>
<td>I elect Employee Paid Life/AD&amp;D</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I decline Employee Paid Life/AD&amp;D</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employee Paid Spouse Voluntary Life and AD&amp;D</th>
<th>Available in $5,000 increments to a max of 50% of the Employee’s benefit amount up to $100,000. <strong>Guaranteed Issue:</strong> $10,000</th>
<th>Election Amount $___________</th>
<th>Premium Per Week $__________</th>
</tr>
</thead>
<tbody>
<tr>
<td>I elect Employee Paid Spouse Life/AD&amp;D</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I decline Employee Paid Spouse Life/AD&amp;D</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employee Paid Child Voluntary Life and AD&amp;D</th>
<th>Child age 14 days to age 23 (age 25 if full-time student): $10,000</th>
<th># of Children covered: ______</th>
<th>Premium Per Week $__________</th>
</tr>
</thead>
<tbody>
<tr>
<td>I elect new or increased coverage amounts.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I decline Employee Paid Child Life/AD&amp;D</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Please refer to the Employee Benefit Guide for premiums.

**Beneficiaries – For Employee Paid Voluntary Life and AD&D Coverage**

<table>
<thead>
<tr>
<th>Last Name, First Name, MI:</th>
<th>Relationship:</th>
<th>Date of Birth:</th>
<th>Phone Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Beneficiary</td>
<td>Secondary Beneficiary</td>
<td>Percentage: _____%</td>
<td></td>
</tr>
<tr>
<td>Primary Beneficiary</td>
<td>Secondary Beneficiary</td>
<td>Percentage: _____%</td>
<td></td>
</tr>
</tbody>
</table>

**Terms and Conditions**

I authorize payroll deductions based on the coverage election(s) indicated above. I authorize all of the above elections made on a pre-tax basis for the 2018 calendar year.

I also understand that the above elections are irrevocable until the next open enrollment period, unless I have a change in family status. A change in family status will include the following: (a) marriage or legal separation/divorce (b) spouse terminating or obtaining employment, (c) transfer to a different employment status (full-time to part-time or vice versa), (d) significant change in spouse’s health coverage, and (e) loss of dependent status or birth or adoption of a child. Only benefit changes consistent with the above will be permitted and must be within 30 days of the change in family status. I understand that I am responsible for notifying the Human Resources Department of any change in family status and for completing the necessary forms within those 31 days.

Date ___________________________                Participant Signature ___________________________
**Note:** Complete this form only if you are requesting benefits for your legal spouse.

**Group Medical Plan Working Spouse Eligibility Affidavit**

**2018**

<table>
<thead>
<tr>
<th>General Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Employee Name</td>
</tr>
<tr>
<td>2 Employee Social Security Number</td>
</tr>
<tr>
<td>3 Employee Date of Birth (mm/dd/yy)</td>
</tr>
<tr>
<td>4 Spouse’s Date of Birth (mm/dd/yy)</td>
</tr>
</tbody>
</table>

5 If your spouse is employed, is he/she eligible to participate in any employer-paid medical coverage through his/her employer?

If yes, your spouse is not eligible to participate in the TANK medical plan. □ Yes □ No

If no, your spouse is eligible to participate in the TANK medical plan.

**Affidavit**

By signing below, I certify that all the information on this form is correct. I authorize any provider of medical services, insurance company, my spouse’s employer or medical benefit plan sponsored or provided by my spouse’s employer, or any other organization to release to TANK, their insurance carrier, or their representative, any information regarding the medical coverage, pricing, contract provisions for us, or our dependent children. (Both signatures are required if your spouse is eligible for medical coverage under his/her employer’s benefit plan.)

Employee Signature: ____________________________________________ Date: ________________

Spouse’s Signature: ____________________________________________ Date: ________________
Introduction
This packet contains step-by-step instructions, and the required forms, needed to complete this year’s wellness program. Please read through it carefully and complete all necessary steps within 90 days of eligibility to earn the reduced wellness rate.

Program Incentive
Participants in the wellness program are eligible to receive a reduced wellness rate by taking a few simple steps to better understand their health:

- Complete Registration and Consent Form
- Complete Tobacco Attestation Form
- Complete Physician Results Form

Once all required action steps are completed, participants will receive a reduced wellness rate within 90 days of eligibility.

If after your paperwork is turned in it is discovered that you have been paying the incorrect premiums, you will immediately be switched to the correct premium. In addition, you will be required to reimburse TANK for the additional premiums that would have been owed had you been paying the correct rate. This will be retroactive to your initial eligibility date.
Welcome to your 2018 Wellness Program. You must complete Steps 1 – 4 below within 90 days to earn a premium differential.

Steps to Earning a Premium Differential

STEP 1: Registration and Consent Form
Complete the Registration and Consent form in its entirety and submit it to forms@wellworksforyou.com to earn credit for this step.

STEP 2: Tobacco Attestation Form
All participants are required to complete this form in its entirety and certify that they are a non-tobacco user or are a tobacco user and have completed an approved tobacco cessation program.

STEP 3: Physician Results Form
Complete an annual physical exam with your physician within 90 days of eligibility. Take this packet with you to your appointment and have your doctor complete and sign the Physician Results Form. It is the participant’s responsibility to return the form as part of the completed packet (see Step 4 below) within 90 days of eligibility.

If you do not have a doctor, you can select a doctor within the Transit Authority of Northern Kentucky health benefit plan network. If you need assistance in finding a physician, please go to www.uhc.com. Little clinics and minute clinics do not qualify as Primary Care Visit completion.

STEP 4: Submit Your Completed Packet within 90 days of eligibility.
Submit your completed packet in its entirety in one of three ways:

✓ Scan and email to: forms@wellworksforyou.com
✓ Secure fax to: 484.887.2223
✓ Mail to: 1615 West Chester Pike, Suite 104
          West Chester, PA 19382
          Attention: Forms Department

Keep a copy of all forms for your files. We will notify you when your packet has been processed. Please allow 7-10 business days for processing.

A Reduced Wellness Rate

QUESTIONS? Please contact Wellworks For You at 800.425.4657.
Complete the information below to register for participation in the wellness program. Your signature is required at the bottom of the form to confirm you have read and understand what is involved in participating in the wellness program.

**PLEASE PRINT CLEARLY**

**Contact Information**

**Company Name:** Transit Authority of Northern Kentucky

**First Name:**

**Last Name:**

**Previous/Maiden Name (if changed in the last 12 months):**

**Date of Birth:**

☐ Male  ☐ Female

**Home Address:**

City:  State:  Zip:

**Phone:**

Email:

**Participation Acknowledgement**

I understand that initiating a follow-up examination to confirm results of any physical screening and obtaining professional medical assistance is my responsibility alone and not that of my health plan, employer or Wellworks For You.

Wellworks For You will disclose to my employer that I had a physical, underwent laboratory testing, and completed a tobacco affidavit. Wellworks For You will make this disclosure in order for my employer to determine eligibility for incentives.

My employer will not have access to any of my specific medical information provided through the Wellness Program. My employer and/or health plan - will have access only to aggregate data to assess population trends ("Aggregate data" does not personally identify me but combines my individually identifiable medical information with those of other participants in the wellness program for review). Through my participation in the program, I consent to all of the following:

- Receipt of aggregate data as described in the previous paragraph by my health plan's/employer's or my spouse's employer/health plan
- Receipt of such aggregate data by my health plan/employer - wellness advisor, USI Insurance Services LLC, and USI Holdings Corporation ("USI")
- Disclosure of my personally identifiable biometric data/report and tobacco affidavit by Wellworks For You to the third-party data analytic vendor specified by my health plan/employer - in order for such vendor to determine my eligibility for medical insurance premium discounts and/or for data aggregation as described above in this form

I affirm that I have read, understand, and agree to the terms set forth above, and I wish to participate in the Wellness Program on the terms specified.

Signature of Participant (Required)  Date
Whether or not a tobacco user, every participant is required to complete and sign the below affidavit to certify that he or she is tobacco-free, a tobacco user not interested in quitting, OR a tobacco user who has completed the company-designated cessation program (considered a Reasonable Alternative Standard) to qualify for the wellness rate.

Contact Information

Company Name: Transit Authority of Northern Kentucky
First Name: 
Last Name: 
Date of Birth: 
Male □ Female □
Phone: 
Email: 

Documentation

- Every participant is required to complete, sign, and submit this tobacco affidavit form to confirm program eligibility, even if a non-tobacco user. If a tobacco cessation form is not completed and submitted as part of your complete wellness program packet, you will be ineligible for the non-tobacco user discount, regardless of your tobacco use.
- Tobacco-use status must be updated by every participant at each annual open enrollment period in order to qualify for the non-tobacco user discount.
- Providing false information on this form will subject the employee to immediate revocation of the discount and can subject the employee to disciplinary action up to and including termination of employment.
- Transit Authority of Northern Kentucky has the right to request documentation at any time from an employee (or, as to the employee, from the vendor) when the employee and/or spouse declares himself/herself a tobacco user enrolled in a tobacco cessation program for the sole purpose of verifying enrollment or activity. An employee or spouse who is unable to provide proof of participation in the approved program is subject to immediate revocation of the discount.

Reasonable Alternative Standard

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you believe you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact Human Resources, and we will work with you and your doctor, if you wish, to find a wellness program with the same reward that is right for you in light of your health status.

Tobacco Status (please check one)

- I do not use tobacco products, including cigarettes, cigars, chewing tobacco, e-cigs, or any other nicotine product and promise not to use these products during this benefit year. I understand that I may be subject to tobacco-use testing.
- I currently use tobacco products.

Please Sign Below

I understand this is a legally binding document and I attest that the above information is accurate to the best of my knowledge. This attestation form is not complete unless I have checked a box in the Tobacco Status section that is relevant to me and have signed and dated the form below.

Signature of Participant (Required) 
Date
Take this form with you to your scheduled annual physical to be completed and signed by your primary care physician. It is the participant’s responsibility to submit the Physician Results Form as part of the complete packet to be returned to Wellworks For You as outlined below.

### Patient Contact Information

<table>
<thead>
<tr>
<th>Company Name:</th>
<th>Transit Authority of Northern Kentucky</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Name:</td>
<td></td>
</tr>
<tr>
<td>Last Name:</td>
<td></td>
</tr>
<tr>
<td>Date of Birth:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ Male     ☐ Female</td>
</tr>
<tr>
<td>Phone:</td>
<td></td>
</tr>
<tr>
<td>Email:</td>
<td></td>
</tr>
</tbody>
</table>

### Physician Information

<table>
<thead>
<tr>
<th>Physician Office/ Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Phone/Address:</td>
</tr>
<tr>
<td>Date of Visit:</td>
</tr>
</tbody>
</table>

This **Results Form** confirms that the patient named above received the following preventative care. The primary care physician needs to complete the information below with an * in front of it and return the completed form to the patient named above.

<table>
<thead>
<tr>
<th><strong>SCREENING</strong></th>
<th><strong>RESULTS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Blood Pressure (Systolic)</em></td>
<td><em>Total Cholesterol</em></td>
</tr>
<tr>
<td><em>Blood Pressure (Diastolic)</em></td>
<td><em>Low Density Lipoprotein (LDL)</em></td>
</tr>
<tr>
<td><em>Height (in inches)</em></td>
<td><em>High Density Lipoprotein (HDL)</em></td>
</tr>
<tr>
<td><em>Waist Circumference</em></td>
<td><em>Triglycerides</em></td>
</tr>
<tr>
<td><em>Weight (in pounds)</em></td>
<td><em>Glucose (fasting)</em></td>
</tr>
<tr>
<td>BMI (Body Mass Index)</td>
<td>T. Cholesterol / HDL Ratio</td>
</tr>
<tr>
<td>Pulse (Heart Rate)</td>
<td>HbA1c <em>(if physician recommended)</em></td>
</tr>
</tbody>
</table>

*Does your patient have a history of coronary artery disease (MI, CABG, PTCA)?*  ☐ Yes  ☐ No

*Does your patient have a history of diabetes?*  ☐ Yes  ☐ No

*If no, does your patient have pre-diabetes?*  ☐ Yes  ☐ No

*Do you, the physician, plan on following up with the patient about their results, medication adherence, or retesting?*  ☐ Yes  ☐ No

### Physician

I certify that the patient listed above received the tests indicated on this form on: _____/_____/______

<table>
<thead>
<tr>
<th>Physician Signature:</th>
<th>Date Signed:</th>
</tr>
</thead>
</table>

*Little clinics and minute clinics do not qualify as Primary Care Visit completion.*
Once you have completed all of the requirements for the wellness program, submit the completed packet to Wellworks For You.

Choose one of the submission methods below:

✓ Scan and email to: forms@wellworksforyou.com
✓ Secure fax to: 484.887.2223
✓ Mail to: 1615 West Chester Pike, Suite 104
          West Chester, PA 19382
          Attention: Forms Department

Keep a copy of all forms for your files. We will notify you when your packet has been processed. Please allow 7-10 business days for processing.

QUESTIONS? Please contact Wellworks For You at 800.425.4657.
Transit Authority of Northern Kentucky 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. You will be asked to complete a biometric screening, which will include a blood test for biometrics, glucose and lipid panel. You are not required to participate in the blood test or other medical examinations. However, employees who choose to participate in the wellness program will receive an incentive of a premium differential for completing the requirements. Although you are not required to participate in the biometric screening, only employees who do so will receive the premium differential.

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 Wellworks For You at 800-425-4657.

The information from your biometric screening will be used to provide you with information to help you understand your current health and potential risks. You are also 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 Transit Authority of Northern Kentucky may use aggregate information it collects to design a program based on identified health risks in the workplace, Wellworks For You 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. The only individual(s) who will receive your personally identifiable health information are the Wellworks For You team in order to provide you with services under the wellness program.

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 Wellworks For You at 800-425-4657.
# Health Savings Account Application

<table>
<thead>
<tr>
<th>HSA OWNER’S NAME</th>
<th>HSA OWNER’S PHYSICAL ADDRESS</th>
<th>HSA CUSTOMIAN’S NAME AND ADDRESS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>BB&amp;T HSA Administration</td>
</tr>
<tr>
<td></td>
<td></td>
<td>P. O. Box 1489</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lumberton, NC  28359-1489</td>
</tr>
<tr>
<td></td>
<td></td>
<td>M/C 151-90-01-05</td>
</tr>
</tbody>
</table>

**Date of Birth**

<table>
<thead>
<tr>
<th>Social Security Number</th>
<th>Home Phone</th>
<th>Business Phone</th>
</tr>
</thead>
</table>

- **Check here if this is an amendment to an existing HSA.**

<table>
<thead>
<tr>
<th>Cell Phone</th>
<th>Email Address</th>
<th>HDHP Plan Type</th>
<th>Mother’s Maiden Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Individual</td>
<td>Family</td>
</tr>
</tbody>
</table>

**Type of ID**

<table>
<thead>
<tr>
<th>Issued by</th>
<th>ID #</th>
<th>Issue Date</th>
<th>Expiration Date</th>
</tr>
</thead>
</table>

- **Employer:**

<table>
<thead>
<tr>
<th>How Long at Employer:</th>
</tr>
</thead>
</table>

**Enroll in BB&T Online**

- **Online User ID**

- **Online Password**

- **Order Checks**

- **Benefit Access Card**

- **BB&T Phone 24 Security Code**

- **Please send me a security code to access automated account information via 800-BANK BBT.**

### DESIGNATION OF BENEFICIARY(ies)

I wish to designate the following individual(s) or entity(ies) as my primary and/or contingent beneficiary(ies). I understand that by not providing any beneficiary information, my beneficiary will default to my estate. I also understand that 1) if neither primary nor contingent is indicated, the individual or entity will be deemed to be a primary beneficiary; 2) if more than one primary beneficiary is designated and no distribution percentages are indicated, the primary beneficiaries listed will share equally; 3) if multiple contingent beneficiaries are listed with no share percentage indicated, the contingent beneficiaries will share equally.

If any primary and/or contingent beneficiary dies before I do, his or her interest and the interest of his or her heirs shall be terminated completely, and the percentage share of any remaining beneficiary(ies) shall be increased on a pro rata basis. If no primary beneficiary(ies) survives me, the contingent beneficiary(ies) shall share based on the share % listed.

<table>
<thead>
<tr>
<th>No.</th>
<th>Name and Address</th>
<th>Date of Birth</th>
<th>Social Security Number</th>
<th>Relationship</th>
<th>Primary or Contingent</th>
<th>Share %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
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<td>Primary</td>
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<td>4.</td>
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<td></td>
<td>Contingent</td>
<td></td>
</tr>
</tbody>
</table>

## SIGNATURES

**Important: PLEASE READ BEFORE SIGNING.** (Please be advised that accounts are subject to credit approval.)

I understand the eligibility requirements for the type of HSA deposit I am making and will make in the future. I also understand that my employer may utilize a Third Party Administrator (“TPA”) or insurance brokerage or other firm to assist in account opening and administrative services on my behalf and in such case, I authorize BB&T to work with these entities as described in the HSA Custodial Agreement and Disclosure. Upon signing below, I certify that I have received a copy of this Health Savings Account Application and the HSA Custodial Agreement and Disclosure. I understand that I will also be mailed a copy of the HSA Custodial Agreement and Disclosure within 3 business days of my account being opened and that I may access a copy from BB&T.com/HSA or request one by contacting the BB&T HSA Department. I understand the terms and conditions contained therein and agree to be bound by those terms and conditions.

Signature of HSA Owner __________________________ Date __________

BB&T Representative __________________________ Date __________

Branch # __________ Officer # __________ Referring Officer # __________ 2nd Referring Officer # __________ CID # __________
TRANSIT AUTHORITY OF NORTHERN KENTUCKY
HRA ENROLLMENT FORM

Employee Name: ________________________________ SS#: __________________________

Employee Address: _____________________________________________________________

Phone number: ___________________________ Email Address: ______________________________

Date of Birth: _____________ Hire Date: _____________ Benefit Eligibility Date: _____________

Dependent Information: (Name and date of birth)

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Please retain one copy of the enrollment form for your records

Your employer is sponsoring a HEALTH REIMBURSEMENT ACCOUNT (HRA) to help cover certain expenses not covered by your primary insurance. Your HRA is administered by CUSTOM DESIGN BENEFITS.

Getting HRA reimbursements

Two easy steps:
- Complete the HRA claim form (you can find it on CDB’s website under Forms & FAQs)
- Scan/Email, Fax or Mail the documentation of the expense with the HRA claim form to:

  MAIL: Custom Design Benefits
  5589 Cheviot Road
  Cincinnati, OH 45247

  EMAIL: CustomFlex@CustomDesignBenefits.com

  FAX: 513-598-2901

Custom Design Benefits will send a check for the amount due which is then used to pay for healthcare expenses. We issue checks on a weekly basis. We also offer DIRECT DEPOSIT of reimbursements with a completed Direct Deposit form.

We will also provide a Custom Flex debit card for you to use to pay your expenses.

Accessing Your HRA Information

ONLINE: www.CustomDesignBenefits.com

PHONE: 800-598-2929 8 - 5 EST, M-F
   866-598-2939 Automated Toll-free, 24/7 access to account balance & reimbursements
Employee Name: (please print) ____________________________ SS#: ____________________________

Check here if new address: ____________________________

City: ____________________________ State: ____________________________ Zip: ____________________________ Date of Birth: ____________________________

E-mail Address: ____________________________ Phone: ____________________________

Date of Hire: ____________________________ Benefit Start Date: ____________________________ Loc/Dept.Code: ____________________________

Pay Periods: 52 Are You Currently Enrolled in a Health Savings Account (HSA) Owned by you or your spouse? Yes ___ NO ___

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of FSA Reimbursement Account</td>
<td>Annual Maximum</td>
<td>Annual Election</td>
<td>Number of Yearly Pay Periods</td>
<td>Deduction Per Pay Period (= C divided by D)</td>
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<td>Healthcare</td>
<td>$2,600</td>
<td>$</td>
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<td></td>
</tr>
<tr>
<td>Dependent Care</td>
<td>*Please complete information below</td>
<td></td>
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<tr>
<td>*Married Filing Joint or Single: $5000 Maximum Allowable</td>
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<tr>
<td>*Married filing separate return: $2500 Maximum Allowable</td>
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</tr>
<tr>
<td>Total</td>
<td></td>
<td>$</td>
<td></td>
<td>$</td>
</tr>
</tbody>
</table>

*Dependent Name (First & Last)

*Date of Birth

I understand that reimbursement will be available only for qualifying health care expenses as defined in Section 213 of the Internal Revenue Code or qualifying dependent care expenses. I agree to notify the Company if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Company on demand for any liability it may incur for failure to withhold federal, state, or local income tax or Social Security tax from any reimbursement I receive of a non-qualifying expense, up to the amount of additional tax actually owed by me.

I understand that:
- I cannot change or revoke this compensation reduction agreement at any time during the plan year unless I have a change in family status (including marriage, divorce, death of spouse or child, birth or adoption of a child, termination or commencement of employment of a spouse, or such other events as the Plan Administrator determines will permit a change or revocation of an election).
- The Plan Administrator may reduce or cancel my compensation reduction or otherwise modify this agreement in the event he or she believes it advisable in order to satisfy certain provisions of the Internal Revenue Code.
- I understand that my participation in the Dependent Care Plan reduces my eligibility for the Federal Child Care Tax Credit.
- I understand that my participation in this plan may reduce my Social Security benefits slightly as a result of my election.

Signature of Employee ____________________________ Date ____________________________

My signature authorizes my employer to make payroll deductions on a pre-tax basis in agreement with the plan benefits elected above.

-----------------------------------------------------------------------------------------------------------------------------

WAIVER OF PARTICIPATION

I understand that I have met all of the eligibility requirements for participation in the above named plan; however, I do not wish to participate at this time. I understand that this refusal will become effective on the first day of the Plan Year. I understand that participation in the Flexible Benefit Plan will not be available to me until next Plan Year and no other benefit is available to me from the above named Plan. I understand that this refusal in no way effects any Employer contributions that may be made to any other Plan sponsored by the Employer.

(Signature of Employee) ____________________________ (Date) ____________________________

This form must be sent through your employer so changes are made to your employee payroll record.

For assistance, you may contact Custom Design Benefits at (800) 598-2929 or (513) 598-2929.
# Enrollment/Change Form for Employee Paid Voluntary Life and AD&D

## Employer Name:
**TRANSIT AUTHORITY OF NORTHERN KENTUCKY**

**Group Plan Number:** 00408638

**Benefits Effective:**

---

### About You:
- **First, MI, Last Name:**
- **Address:**
- **City:**
- **State:**
- **Zip:**
- **Gender:** M, F
- **Date of Birth (mm-dd-yyyy):**
- **Phone:**
- **Email Address:**
- **Are you married or do you have a spouse?** Yes, No
- **Date of marriage/union:**
- **Do you have children or other dependents?** Yes, No
- **Placement date of adopted child:**

### About Your Job:
- **Hours worked per week:**
- **Job Title:**

### About Your Family:
- **Spouse (First, MI, Last Name):**
  - **Address/City/State/Zip:**
  - **Phone:**
- **Child/Dependent 1:**
  - **Address/City/State/Zip:**
  - **Phone:**
- **Child/Dependent 2:**
  - **Address/City/State/Zip:**
  - **Phone:**

---

**CEF2014-KY**

**DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER**

**DATE FORM PUBLISHED:** Sep 10, 2016
<table>
<thead>
<tr>
<th>Child/Dependent 3:</th>
<th>Add</th>
<th>Drop</th>
<th>Gender</th>
<th>Social Security Number</th>
<th>Date of Birth (mm-dd-yyyy)</th>
<th>Status (check all that apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address/City/State/Zip:</td>
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<td></td>
<td></td>
<td></td>
<td>q Student (post high school) q Disabled q Non standard dependent</td>
</tr>
<tr>
<td>Phone: (   ) -</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Child/Dependent 4:</th>
<th>Add</th>
<th>Drop</th>
<th>Gender</th>
<th>Social Security Number</th>
<th>Date of Birth (mm-dd-yyyy)</th>
<th>Status (check all that apply)</th>
</tr>
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<tbody>
<tr>
<td>Address/City/State/Zip:</td>
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<td></td>
<td></td>
<td></td>
<td>q Student (post high school) q Disabled q Non standard dependent</td>
</tr>
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<td>Phone: (   ) -</td>
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**Drop Coverage:**
- q Drop Employee
- q Drop Dependents

The date of withdrawal cannot be prior to the date this form is completed and signed.

- Last Day of Coverage: _______ - _______ - _______
- q Termination of Employment
- q Retirement
- Last Day Worked: _______ - _______ - _______
- q Other Event: __________________________ |

- Date of Event: _______ - _______ - _______

I have been offered the above coverage(s) and wish to drop enrollment for the following reasons:
- q Covered under another insurance plan
- q Other

(additional information may be required)

**Voluntary Term Life Coverage:**

You must be enrolled to cover your dependents. Benefit reductions apply. Please see plan administrator.

**Employee**

<table>
<thead>
<tr>
<th>Policy Amount</th>
<th>Check one box only</th>
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<tr>
<td>$10,000</td>
<td>q $20,000</td>
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<tr>
<td>$70,000</td>
<td>q $80,000</td>
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<tr>
<td>$130,000</td>
<td>q $140,000</td>
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<tr>
<td>$190,000</td>
<td>q $200,000</td>
</tr>
</tbody>
</table>

- q $30,000
- q $40,000
- q $50,000
- q $60,000
- q $90,000
- q $100,000
- q $150,000
- q $160,000
- q $170,000
- q $180,000

*Guarantee Issue Amount. **Guarantee Issue Amount plus Additional Amount. The Guarantee Issue with Additional Amount is $150,000**.

**Add Voluntary Life for Spouse**

- q 50% of employee’s amount to maximum $50,000

The Guaranteed Issue Amount is $10,000. The Guaranteed Issue with Additional Amount is $50,000.

*The amount may not be more than 50% of the employee amount for Voluntary Life.*

**Add Voluntary Life for Dependent/Child(ren)**

- q 10% of employee’s amount to maximum $10,000

The Guaranteed Issue Amount is $10,000. The Guaranteed Issue with Additional Amount is $10,000.

*The amount may not be more than 10% of the employee amount for Voluntary Life.*

I do not want this coverage.

**Important Notes:**
- Based on your plan benefits and age, you may be required to complete an evidence of insurability form for Voluntary Life.
LIFE INSURANCE continued

Name your beneficiaries: (Primary beneficiary percentages must total 100%)

Primary Beneficiaries:
Name: ___________________________ Social Security Number: _______ - _______ - _______ %
Date of Birth (mm-dd-yy): _______ - _______ - _______ Address/City/State/Zip: __________________________
Phone: (______) _______ - __________ Relationship to Employee: __________________________
Name: ___________________________ Social Security Number: _______ - _______ - _______ %
Date of Birth (mm-dd-yy): _______ - _______ - _______ Address/City/State/Zip: __________________________
Phone: (______) _______ - _______ Relationship to Employee: __________________________
Name: ___________________________ Social Security Number: _______ - _______ - _______ %
Date of Birth (mm-dd-yy): _______ - _______ - _______ Address/City/State/Zip: __________________________
Phone: (______) _______ - _______ Relationship to Employee: __________________________

(Contingent Beneficiary: Social Security Number: _______ - _______ - _______)
Date of Birth (mm-dd-yy): _______ - _______ - _______ Address/City/State/Zip: __________________________
Phone: (______) _______ - _______ Relationship to Employee: __________________________

(If the primary beneficiaries are deceased, the contingent beneficiary will receive the benefit. Employer maintains beneficiary information.)

Health History
Complete the following question(s) if you are enrolling for one or more of the following benefits listed below. NOTE: Additional information may be required.

Voluntary Life
In the last 6 months have you or any of your dependents received medical care, including treatment, consultation services, diagnostic measures or monitoring of a condition in remission; or taken prescribed drugs for: Cancer, Heart Disease, Diabetes; or any other Chronic Condition?

☐ Yes, I have.
☐ No, I haven’t.
☐ Yes, my spouse has.
☐ No, my spouse hasn’t.
☐ Yes, my dependent child(ren) have.
☐ No, my dependent child(ren) haven’t.

Have you or any of your dependents tested positive for exposure to the HIV infection or been diagnosed as having AIDS Related Complex (ARC) or AIDS caused by the HIV infection or other sickness or condition derived from such infection?

☐ Yes, I have.
☐ No I haven’t.
☐ Yes, my spouse has.
☐ No, my spouse hasn’t.
☐ Yes, my dependent child(ren) have.
☐ No, my dependent child(ren) haven’t.

An Evidence of Insurability form must be completed for any person with a “Yes” answer to the question(s) above.

Signature
☐ I understand that life insurance coverage for a dependent, other than a newborn child, will not take effect if that dependent is confined to a hospital or other health care facility, or is home confined, or is unable to perform the normal activities of someone of like age and sex.

☐ I understand that my dependent(s) cannot be enrolled for a coverage if I am not enrolled for that coverage.

☐ I understand that the premium amounts shown above are estimations and are for illustrative purposes only.

☐ Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements as set forth in the applicable benefit booklet.

☐ I understand that I must be actively at work or my elected coverage will not take effect until I have met the eligibility requirements (as defined in the benefit booklet.) This does not apply to eligible retirees.

☐ If coverage is waived and you later decide to enroll, late entrant penalties may apply. You may also have to provide, at your own expense, proof of each person’s insurability. Guardian or its designee has the right to reject your request.

☐ Plan design limitations and exclusions may apply. For complete details of coverage, please refer to your benefit booklet. State limitations may apply.

☐ Your coverage will not be effective until approved by a Guardian or its designated underwriter.

☐ I hereby apply for the group benefit(s) that I have chosen above.

☐ I understand that I must meet eligibility requirements for all coverages that I have chosen above.

☐ I agree that my employer may deduct premiums from my pay if they are required for the coverage I have chosen above.

☐ I acknowledge and consent to receiving electronic copies of applicable insurance related documents, in lieu of paper copies, to the extent permitted by applicable law. I may change this election only by providing thirty (30) day prior written notice.
I state that the information provided above is true and correct to the best of my knowledge.

Any person who with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any materially, false information or conceals for purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits.

The state in which you reside may have a specific state fraud warning. Please refer to the attached Fraud Warning Statements page.

The laws of New York require the following statement appear: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. (Does not apply to Life Insurance.)

SIGNATURE OF EMPLOYEE ___________________________ DATE ___________________________

Fraud Warning Statements

The laws of several states require the following statements to appear on the enrollment form:

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California: For your protection California law requires the following to appear on this form: The falsity of any statement in the application shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Connecticut, Iowa, Nebraska, and Oregon: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of a fraudulent insurance act, which may be a crime, and may also be subject to civil penalties.

Delaware, Indiana and Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kansas: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of insurance fraud as determined by a court of law.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of a fraudulent insurance act, which is a crime.

Louisiana and Texas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinements in state prison.

Maine, Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Rhode Island: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in N.H. Rev. Stat. Ann. §638:20.
Please complete this form in ink. As a convenient alternative, for Life and Disability coverages, this form can be completed at www.guardiananytime.com/eoi. Complete the following information for each person to be underwritten:

<table>
<thead>
<tr>
<th>Planholder Name (Company Name)</th>
<th>Group Plan No.</th>
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<tbody>
<tr>
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<tr>
<th>Name (Last, First, Middle Initial)</th>
<th>Sex</th>
<th>Birthdate</th>
<th>Height</th>
<th>Weight</th>
<th>Full time</th>
<th>Student</th>
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<tr>
<td>Employee:</td>
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<td></td>
<td></td>
<td></td>
<td>Yes</td>
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<tr>
<td>Employee Home Address:</td>
<td></td>
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<tr>
<td>Preferred Method of Contact:</td>
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<td>Employee Telephone Number:</td>
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<tr>
<td>Date of Hire:</td>
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<tr>
<td>Cell Phone:</td>
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<td>E-mail Address:</td>
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</tr>
<tr>
<td>Spouse:</td>
<td>M</td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Child:</td>
<td>M</td>
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<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Child:</td>
<td>M</td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
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</table>

<table>
<thead>
<tr>
<th>Employee’s Social Security Number:</th>
<th>Date of Marriage:</th>
<th>Employee’s Place of Birth (State):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Employee Amount of Insurance Currently Inforce:</th>
<th>Spouse Amount of Insurance Currently Inforce:</th>
<th>Child Amount of Insurance Currently Inforce:</th>
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<tr>
<th>Employee’s Insurance Amount Elected:</th>
<th>Spouse Insurance Amount Elected:</th>
<th>Child Insurance Amount Elected:</th>
</tr>
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<tbody>
<tr>
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</table>

**Section I: IF APPLYING FOR LIFE INSURANCE, questions 1-4 must be answered by each person applying for coverage. However, if applying for coverage for a child, the Employee must complete questions 1-4 for the child applying for coverage. IF APPLYING FOR DISABILITY INSURANCE, questions 1-5 must only be answered by the Employee.**

1. In the past 10 years, has any proposed insured been treated for or diagnosed as having any of the following: a) any disorder or condition of the heart; liver, kidney(s); lung or respiratory system; b) any disorder or condition of your digestive system including your esophagus, stomach, or intestines; c) any mental, nervous, emotional or neurological disorder or condition; d) auto immune disorder; e) diabetes; f) cancer; or g) a stroke?

   - Employee [ ] Yes [ ] No
   - Spouse [ ] Yes [ ] No
   - Child [ ] Yes [ ] No

2. In the past 5 years, has any proposed insured: used any illegal drugs; used prescription medication other than as prescribed; been treated for alcoholism or drug use or dependency; or been advised to seek treatment for alcoholism, drug abuse or drug dependency?

   - Employee [ ] Yes [ ] No
   - Spouse [ ] Yes [ ] No
   - Child [ ] Yes [ ] No

3. Has any proposed insured ever tested positive for HIV (Human Immunodeficiency Virus) antibodies?

   - Employee [ ] Yes [ ] No
   - Spouse [ ] Yes [ ] No
   - Child [ ] Yes [ ] No

4. In the past year, has any proposed insured: (a) consulted or been examined by or treated by a physician, practitioner or specialist for any illness or injury, disease or disorder NOT listed in the questions above (including routine physicals only when there is an existing or newly diagnosed medical condition); or (b) sought treatment or a consultation in a hospital or other health care facility for observation, diagnosis, treatment or an operation; undergone any diagnostic testing including but not limited to X ray, blood work, ultrasound, an MRI, a CT scan, or PET scan with abnormal findings; or been prescribed medication(s) – (other than for colds, flu or allergies)?

   - Employee [ ] Yes [ ] No
   - Spouse [ ] Yes [ ] No
   - Child [ ] Yes [ ] No

5. **If applying for disability coverage, please complete these additional questions:**

   (a) In the past 5 years, has any proposed insured been treated for any disorder or condition of the back, neck, spine; arthritis; or any muscular skeletal disorder or condition?

   - Employee [ ] Yes [ ] No

   (b) Are you currently pregnant?

   - Employee [ ] Yes [ ] No

Please retain a copy for your records and submit this form to Guardian.
For each "yes" answer to question 1 through 5 give details below. (Continue on reverse side if additional space is needed.)

<table>
<thead>
<tr>
<th>Question #</th>
<th>Name</th>
<th>Test, Injury, Illness, Disease, Operation or Complication</th>
<th>Date of Onset</th>
<th>Recovery</th>
<th>Full Details (including Doctors’ Names and Addresses)</th>
</tr>
</thead>
<tbody>
<tr>
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</table>
Representations of the Proposed Insured(s) and Authorization Please read and sign below.

Part I. Representations of the Proposed Insured

Those parties who sign below hereby represent that the statements and answers to the question(s) are, to the best of the knowledge and belief of the party signing below, full, complete, true and correctly recorded. Those parties who sign below understand that they will form the basis of any coverage under the Group Plan for which Evidence of Insurability is required. When used in this Part I, “I” refers to the person applying for insurance signing below.

Also, it is mutually understood and agreed that (1) the Company reserves the right to request, at its expense (except in the case of a late entrant, it is not at the Company’s expense), that any proposed insured be examined by an accredited medical examiner selected by the Company; (2) no Group Insurance will be binding or in force until satisfactory evidence of insurability is submitted, approved by the Company and the required premiums are received by the Company; and: (a) I am actively at work on a full-time basis (as defined in the Group Plan) for full pay on the date my Group Insurance becomes effective; otherwise, (b) I become insured on the date I do return to work and satisfy a waiting period (as defined in the Group Plan) of full-time service; (3) coverage for my dependents will not take effect if a dependent other than a newborn is: (a) confined to the hospital or other health care facility; or (b) is unable to perform the normal activities of someone of like age and sex; (4) no person, except the President, a Vice President or a Secretary of the Company, has authority to: (a) determine whether any contract(s) of insurance shall be issued on the basis of the application; (b) waive or modify any of the provisions of the application or any of the Company’s requirements; (c) bind the Company by any statement or promise pertaining to any insurance contract(s) issued or to be issued on the basis of the application; or (d) accept any information or representation not contained in the written application; (5) the employer is hereby named the Proposed Insured’s representative for the purpose of receiving premiums and remitting them to the Company. In the event the Company receives premiums in excess of the appropriate amount for the coverage provided, the Company will only be liable for the overpaid premiums plus applicable interest.

Any misrepresentation or omission, if found to be material, may adversely affect acceptance of the risk, claims payment or may lead to rescission of any coverage issued based on this Evidence of Insurability Form.

Part II. Authorization to Obtain Information (Medical Records and other information)

I authorize my physician, medical practitioner, hospital, clinic, other health facility, practitioner, mental health professional, pharmacy or pharmacy benefit manager, laboratory, the MIB, Inc., insurance or reinsurance company, group policyholder, benefit plan administrator, employer, other organization, institution or person that has any records or knowledge of the Proposed Insured or his/her health, business associate, other person or organization to release any and all medical and non-medical information in its possession about me, to The Guardian Life Insurance Company of America or its legal representatives. Medical information means all information in the possession of or derived from providers of health care regarding the medical history, pharmaceutical history, and all past and present physical, mental, drug and alcohol condition, or treatment of me. Non-medical information includes employment history, job duties, and any wage or earnings information. I understand that the information released could contain reference to or results of HIV Antibody (AIDS) testing, and may relate to the symptoms, evaluation, diagnosis, examination, treatment or prognosis of any mental or physical condition, including psychiatric, and psychological conditions, and drug or alcohol abuse.

I understand that Guardian will use the information obtained by this authorization to determine eligibility for insurance or eligibility for benefits under an existing plan. I further understand that if I refuse to sign this authorization, the Company may not be able to process my application, or pay a claim in the case of coverage which is already in force. Guardian will not release any information obtained to any person or organization except to reinsurance companies, the MIB, Inc., or other persons or organizations performing business or legal services in connection with my application, claim or as may be lawfully permitted or required, or as I may fully authorize. I understand that any information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal regulations governing privacy (such as the HIPAA Privacy Rule).

By my signature below, I authorize the Company or its legal representatives to make a brief report of my personal health information to the MIB, Inc.

I know that I may revoke this authorization in writing, at any time, by sending a written request for revocation to the Guardian Corporate Secretary at 7 Hanover Square, New York, NY 10004-2616. I understand that a revocation is not effective to the extent that the Company and/or any of the entities listed above has already relied on this authorization, or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself.

I know that I may request and receive a copy of this authorization.
I agree that a photocopy of this authorization will be as valid as the original. I agree that this authorization will be valid for two and one half years from the date shown below.

Any person who with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any materially, false information, or conceals for purpose of misleading information concerning any fact material hereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits.

The state in which you reside may have a specific state fraud warning. Please refer to the Fraud Warning Statements page below.

The laws of New York require the following statement appear: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. (Does not apply to Life Insurance.)

By my signature below,
1. I agree with all of the terms, conditions, statements, and representations stated above in Part I. Representations of the Proposed Insured; and
2. I agree and consent to the Company obtaining and disclosing the information as stated above in Part II. Authorization to Obtain Information (Medical Records and Other Information) and with all other terms and conditions stated therein.

_______________________________________________________ _________________
Signature of Employee                                      Date

_______________________________________________________ _________________
Signature of Spouse                                        Date

Please retain a copy for your records and submit this form to Guardian

EOI2012-IN

GG-016698-IN (6/14)
Insurance Information Practices Please read and detach for your records

Thank you for choosing The Guardian Life Insurance Company of America (“Guardian”). This notice is given to you at the time you apply for life or disability insurance to tell you about the kinds of information we may obtain in connection with your application. We will treat all personal information about you as confidential, except as authorized by you, or as required by law. You have a right of access and correction with respect to this information. If you wish a more detailed explanation of our information practices, please send your written request to: The Privacy Office, The Guardian Life Insurance Company of America, 7 Hanover Square, New York, NY 10004-4025.

MIB, Inc. Pre-Notice: Information regarding your insurability will be treated as confidential. Guardian, or its reinsurers may, however, make a brief report thereon to MIB, Inc., a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB, Inc. member company for life, health or disability insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information it may have in your file. Please contact MIB, Inc., at 866 692-6901 (TTY 866 346-3642). If you question the accuracy of the information in your MIB, Inc. file, you may contact MIB, Inc., and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB, Inc., information office is 50 Braintree Hill Park, Suite 400, Braintree MA 02184-8734.

Guardian, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life, health, or disability insurance, or to whom a claim for benefits may be submitted.

Medical Records: We may request information from health care providers or others who have records of your medical history, mental or physical condition, or treatment. Only qualified members of Guardian’s staff will have access to your medical file to evaluate your eligibility for insurance or to service your claim for benefits under a policy. Your authorization will govern our request for information and any later disclosure of that information.
Fraud Warning Statements

The laws of several states require the following statements to appear on the evidence of insurability form:

**Alabama**: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines or confinement in prison, or any combination thereof.

**Arizona**: For your protection Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

**California**: For your protection California law requires the following to appear on this form: The falsity of any statement in the application shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

**Colorado**: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**Connecticut, Iowa, Kansas, Nebraska, Oregon, and Vermont**: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of a fraudulent insurance act, which may be a crime, and may also be subject to civil penalties.

**Delaware, Indiana and Oklahoma**: WARNING: Any person who knowingly, and with the intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**District of Columbia**: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

**Florida**: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony.

**Kentucky**: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**Louisiana and Texas**: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinement in state prison.

**New Mexico**: Any person who knowingly presents a false or fraudulent claim for payment or a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties or denial of insurance benefits.

**Maine, Tennessee, Virginia and Washington**: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefit.

**Maryland**: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Minnesota**: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**New Hampshire**: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in N.H. Rev. Stat. Ann. § 638:20.

**New Jersey**: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**Ohio**: Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Pennsylvania**: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Rhode Island**: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
We recognize that benefits are an integral and valuable component of your total compensation package. At Transit Authority of Northern Kentucky (TANK), we provide you with a comprehensive, high quality and affordable benefits program that meets your family’s needs.

Please take a moment to read through this brochure to familiarize yourself with the benefits available to you as an employee of TANK. This brochure is intended to be a high level summary of the benefit plans we are offering effective January 1, 2018.

Medical Plan Options
TANK offers a choice of two medical plans. Each plan offers different levels of copays, deductibles and out-of-pocket maximums.

The HDHP HSA 2000 Plan
- $2,000 single deductible
- $4,000 family deductible
- 100% coverage after deductible
- Preventive care services are covered at 100%

The HDHP HSA 2700 Plan
- $2,700 single deductible
- $5,400 family deductible
- 100% coverage after deductible
- Preventive care services are covered at 100%

Health Savings Account (HSA)
- Employees enrolled in a TANK High Deductible medical plan are eligible
- $1,000 lump sum contribution from TANK
- Balances roll year over year
- Employees can contribute to maximum allowed - $3,450 single / $6,850 family

Health Reimbursement Account (HRA)
- Employees that are enrolled in the TANK High Deductible medical plan and enrolled in Medicare are eligible
- If enrolled in Medicare, you are not eligible for a Health Savings Account
- TANK will reimburse up to $1,000 of dollars you pay towards your deductible through the HRA
- No employee contributions

Flexible Spending Account (FSA)
- All employees are eligible for a FSA dependent care or healthcare account.
- You can have an HSA or HRA alongside a FSA dependent care account. You cannot have a HSA and FSA healthcare account.
- Maximum $5,000 for dependent care.
- Use It or Lose It Benefit

Choose a Provider & Choose Your Cost
In-Network providers have contracts with United HealthCare and the savings are passed on to you! Using In-Network providers will keep your out-of-pocket costs down with a lower coinsurance amount.

When care is received from a provider or facility that is not in the network, out-of-pocket costs will be higher. The choice is yours.

Wellness/Non-Wellness Rates
- For 2018, you will be eligible for a Wellness or Non-Wellness rate based on completion of a Tobacco Affidavit and completion of an annual physical and biometric screenings
- Smoking Affidavit required
- Annual Physical required
- Biometric screening required

Have Questions about Your Benefits?
If you have any benefits-related questions, in addition to Human Resources, you have an additional resource, the Benefit Resource Center, a “benefits call center” that is staffed with benefits experts who can assist you with any questions you have about your benefit plans.

They can assist you with enrollment problems, benefit coverage questions and claim issues as well as help you obtain a new ID card.

The Benefit Resource Center can be reached at 855-USI-6699 (855-874-6699) Monday thru Friday 8 am to 5 pm EST, or by email at BRCEast@usi.com.
Eligibility & Enrollment - Eligibility: after 60 days of employment

- Employees working **at least 30 hours** are eligible to participate in the TANK Employee Benefits Program.
- Part-time employee working **less than 30 hours**, you are eligible to enroll for **dental and vision** benefits.
- Part-time employees working **at least 17.5 hours per week** are eligible to enroll for **Guardian voluntary life coverage**.
- Based on your coverage eligibility, you may also enroll your eligible dependents in the TANK Plans. Your eligible dependents include your legal spouse and your married or unmarried children up to the age of 26.

**Note:** If your spouse is offered medical coverage through his/her employer, they are not eligible to be on the TANK medical plan. If enrolling a spouse in the TANK medical plan, you will be required to sign a Working Spouse Eligibility Affidavit.

When does coverage begin?

The benefits you elect as a new hire will be **effective 61 days after your hire date** and will continue through December 31st of the coverage year. If you decline coverage when you are hired, you will be able to enroll during the next Annual Enrollment period or earlier if you have a qualifying life event.

A qualifying life event is not limited to, but may include:

- Change in your legal marital status (marriage, divorce, or legal separation)
- Change in number of dependents (birth or adoption, child turns age 26)
- Change in your spouse’s employment status (resulting in a loss or gain of coverage)
- Death
- Entitlement to or loss of Medicare or Medicaid
- Change in your address or location that affects the plans for which you are eligible
- Significant change in the cost of coverage for you or your spouse’s benefits

You have 30 days from the date of a qualifying life event to make changes to your coverage. If you do not make a change within 30 days, you must wait until the next Annual Enrollment period or another qualifying event to make a change.

When does coverage end?

- Benefits continue through December 31st for all active employees
- Should your employment terminate during the year, your benefits will terminate on your last day worked
- If you have funds in your FSA, you have 90 days to request reimbursement for expenses incurred prior to your termination date
Cost of Coverage: How You Pay for Health Care Costs

You share the cost of health care services with TANK and the medical plan you select. As you review the medical plan options you should consider the following types of costs:

**Premium:** A premium is the total cost for your medical insurance. You and your employer share this cost. **TANK pays 80% of the total premium and you are responsible for 20% of the premium.** You pay your portion through payroll deductions.

**Deductible:** A deductible is the amount you must pay before the medical plan begins sharing the cost of services. You pay this full amount, if required by your plan, before TANK pays benefits.

**Coinsurance:** When you are paying coinsurance, you are sharing a percentage of the cost of services with the medical plan. For example, in the HDHP HSA 2000 plan, after you satisfy your deductible, you will be covered 100% for inpatient medical care that you receive from preferred providers.

**Out-of-Pocket Maximum:** The annual out-of-pocket maximum protects you from major medical expenses. This is the most you would pay and includes your medical deductible, medical copays, pharmacy copays and coinsurance, for eligible expenses during a plan year. Once you reach the out-of-pocket maximum, TANK pays 100% of the usual, customary and reasonable charges for the balance of the calendar year.

**Total Costs:** Remember, the total cost you pay for health care services in a plan year is the combination of your out-of-pocket costs when you access medical care and the premium payments you are required to make for coverage.

\[
\text{Premiums} + \text{Out-of-Pocket Costs} = \text{Total Cost of Health Care}
\]

This Benefits Guide has been prepared to help you review the key factors that are associated with our benefit plans. This Benefits Guide does not provide all of the contractual provisions, limitations or exclusions included in our policies and should be considered only as a summary of our current benefits. If any differences exist between this summary and the official contracts, the contracts shall prevail.
Medical Plans

Eligibility: Full time – after 60 days of employment


<table>
<thead>
<tr>
<th>HDHP HSA 2000 Plan</th>
<th>HDHP HSA 2700 Plan</th>
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<tbody>
<tr>
<td>In-Network Non-Embedded</td>
<td>In-Network Embedded</td>
</tr>
<tr>
<td>Calendar Year Deductible Single/Family</td>
<td>$2,000/$4,000</td>
</tr>
<tr>
<td>Coinsurance (You Pay)</td>
<td>0% After Deductible</td>
</tr>
<tr>
<td>HSA Contribution</td>
<td>$1,000</td>
</tr>
<tr>
<td>HRA Contribution (Medicare Only)</td>
<td>$1,000</td>
</tr>
<tr>
<td>Calendar Year Out of Pocket Maximum</td>
<td>$6,250/$6,850</td>
</tr>
<tr>
<td>Physician Office Visit (You Pay)</td>
<td>0% After Deductible</td>
</tr>
<tr>
<td>Specialists Office Visit (You Pay)</td>
<td>0% After Deductible</td>
</tr>
<tr>
<td>Preventive Care</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>Urgent Care (You Pay)</td>
<td>0% After Deductible</td>
</tr>
<tr>
<td>Emergency Room (You Pay)</td>
<td>0% After Deductible</td>
</tr>
<tr>
<td>Retail Prescriptions (You Pay)</td>
<td>$10 copay after deductible – Tier 1 $35 copay after deductible – Tier 2 $60 copay after deductible – Tier 3</td>
</tr>
<tr>
<td>Employee Contributions</td>
<td>Wellness Non-Wellness Wellness Non-Wellness</td>
</tr>
<tr>
<td>Employee</td>
<td>$35.58</td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$80.06</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$76.50</td>
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<tr>
<td>Family</td>
<td>$99.63</td>
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</table>

**Embedded**: The individual deductible is embedded in the family deductible so that an individual can meet their deductible and have insurance cover their medical bills prior to the entire dollar amount of the family deductible being met. For example, once an individual meets their deductible, any subsequent medical bills for that individual will be paid by insurance and the individual will only be responsible for any applicable coinsurance.

**Non-Embedded**: The individual deductible is not embedded in the family deductible so before an individual’s insurance coverage kicks in, the entire family deductible must be met first. It can be met by one family member or a combination of family members, however, there are no benefits until expenses equaling the family deductible amount have been met.

This Benefits Guide has been prepared to help you review the key factors that are associated with our benefit plans. This Benefits Guide does not provide all of the contractual provisions, limitations or exclusions included in our policies and should be considered only as a summary of our current benefits. If any differences exist between this summary and the official contracts, the contracts shall prevail.
# Which Plan is Best for Me?

<table>
<thead>
<tr>
<th>HDHP HSA 2000</th>
<th>HDHP HSA 2700</th>
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<tbody>
<tr>
<td>• Higher per paycheck cost &amp; lower deductible</td>
<td>• Lower per paycheck cost &amp; higher deductible</td>
</tr>
<tr>
<td>• Must satisfy full deductible for all services, excluding preventive Physician visits, before coverage begins</td>
<td>• Must satisfy full deductible for all services, excluding preventive Physician visits, before coverage begins</td>
</tr>
<tr>
<td>• Prescriptions are subject to the deductible and also apply to the out of pocket maximum</td>
<td>• Prescriptions are subject to the deductible and also apply to the out of pocket maximum</td>
</tr>
<tr>
<td>• Can establish a HSA to cover current and future healthcare expenses (medical, dental, Rx, vision, etc.)</td>
<td>• Can establish a HSA to cover current and future healthcare expenses (medical, dental, Rx, vision, etc.)</td>
</tr>
<tr>
<td>• Non-Embedded Deductible – before an individual’s insurance coverage kicks in, the entire family deductible must be met first. It can be met by one family member or a combination of family members, however, there are no benefits until expenses equaling the family deductible amount have been met.</td>
<td>• Embedded Deductible - The individual deductible is embedded in the family deductible so that an individual can meet their deductible and have insurance cover their medical bills prior to the entire dollar amount of the family deductible being met. For example, once an individual meets their deductible, any subsequent medical bills for that individual will be paid by insurance and the individual will only be responsible for any applicable coinsurance</td>
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Health Savings Account (HSA)

A Health Savings Account (HSA), administered through BB&T, is a tax-exempt custodial bank account created exclusively to pay for qualified medical expenses of the account holder/employee and his/her spouse or tax dependents enrolled in the plans. **You are eligible to contribute to a Health Savings Account (HSA) if you are enrolled in a TANK sponsored HDHP medical plan.**

**Eligibility:**
- You are enrolled in a High Deductible Health Plan (also called a HDHP)
- You are not enrolled in Medicare or Veteran’s benefits
- You are not a dependent on someone else’s tax return

**Here is how the HSA works:**

You may set aside pre-tax dollars from your check to your HSA account based on the IRS Maximum Contributions below. Employee contributions are deposited with each regular payroll cycle. For more information on Health Savings eligible expenses, please go to http://www.irs.gov/pub/irs-pdf/p502.pdf.

<table>
<thead>
<tr>
<th>IRS Maximum Contributions</th>
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<tr>
<td><strong>Single</strong></td>
<td>$3,450</td>
</tr>
<tr>
<td><strong>Family</strong></td>
<td>$6,850</td>
</tr>
<tr>
<td><strong>Catch Up (over 55)</strong></td>
<td>$1,000</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>TANK Contribution</th>
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</thead>
<tbody>
<tr>
<td><strong>$1,000</strong></td>
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</tbody>
</table>

The amount an employee has in his/her HSA can be withdrawn tax-free for qualified medical expenses including dental, vision, chiropractic care, eyeglasses, hearing aids and over-the-counter drugs. You must have a written prescription from your physician for over-the-counter expenses to be eligible.

**The best part of the HSA is that any money you don’t spend rolls over from year to year (unlike money in a flexible spending account). This way, you can start building up a reserve for future medical expenses that you and your family may incur.**

**Since you pay via payroll deduction, your contributions are pre-tax.** Your interest and investment earnings are tax-free. Your reimbursements for any qualified medical expenses are tax-free. Remember: if you use the money for anything other than qualified medical expenses, you will owe a 20% penalty plus ordinary income tax on the funds used. (Note: if you are age 65 or older there is not a 20% penalty on funds you withdraw to pay for non-qualified expenses).
Health Reimbursement Account (HRA)

*Only for those that are enrolled in the TANK HDHP and are also enrolled in Medicare or receiving Veteran's benefits.*

A Health Reimbursement Account (HRA) is available for employees that are not eligible for contributions into a Health Savings Account. This would represent employees that are currently enrolled in the TANK HDHP Plan and are also enrolled on Medicare. The HRA account is funded entirely by TANK; you don’t contribute any money to this account.

- **TANK will contribute $1,000 into a Health Reimbursement Account**

- Employees cannot contribute towards the HRA

- Employees on Medicare or Veteran’s benefits that receive the HRA can contribute to a HealthCare FSA to accumulate additional healthcare dollars

**NOTE:** If you are enrolled in the Health Reimbursement Account (HRA) and the Flexible Spending Account (FSA) you will receive only one debit card that contains all contributions for both the HRA and FSA.
How does my other insurance work with Medicare?

When you elect Medicare, you can:

- Opt to discontinue your medical coverage through TANK
- Opt to have your TANK coverage and Medicare

If you have TANK coverage and Medicare, there are rules regarding when Medicare pays first:

<table>
<thead>
<tr>
<th>Situation</th>
<th>Medicare Pays First</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have retiree insurance (insurance from your or your spouse’s former employment)…</td>
<td>Medicare pays first.</td>
</tr>
<tr>
<td>If you’re 65 or older, have group health plan coverage based on your or your spouse’s current employment, and the employer has 20 or more employees…</td>
<td>Your group health plan pays first.</td>
</tr>
<tr>
<td>If you’re 65 or older, have group health plan coverage based on your or your spouse’s current employment, and the employer has fewer than 20 employees…</td>
<td>Medicare pays first.</td>
</tr>
<tr>
<td>If you’re under 65 and disabled, have group health plan coverage based on your, a spouse’s, or a family member’s current employment, and the employer has 100 or more employees…</td>
<td>Your group health plan pays first.</td>
</tr>
<tr>
<td>If you’re under 65 and disabled, have group health plan coverage based on your or a family member’s current employment, and the employer has fewer than 100 employees…</td>
<td>Medicare pays first.</td>
</tr>
<tr>
<td>If you have Medicare because of End-Stage Renal Disease (ESRD)…</td>
<td>Your group health plan will pay first for the first 30 months after you become eligible to enroll in Medicare. Medicare will pay first after this 30-month period.</td>
</tr>
</tbody>
</table>
How does my other insurance work with Veteran’s benefits?

Why does VA require me to provide information on my health insurance coverage (including coverage under a spouse’s plan)?

We ask for this information because we have to bill your private health insurance provider for any care, supplies, or medicine we provide to treat your non-service-connected conditions (illnesses or injuries that aren’t related to your military service).

We don’t bill Medicare or Medicaid, but we may bill Medicare supplemental health insurance for covered services.

What if my health insurance provider doesn’t cover all the non-service-connected care that VA bills them for?

You won’t have to pay any unpaid balance not covered by your health insurance provider. But, depending on your eligibility priority group, you may have to pay a VA copayment for non-service-connected care. Learn more about eligibility priority groups.

Does it help me in any way to give VA my health insurance information?

Yes. Giving us your health insurance information helps you because:

- When your private health insurance provider pays us for your non-service-connected care, we may be able to use the funds to offset part—or all—of your VA copayment.
- Your private insurer may apply your VA health care charges toward your annual deductible (the amount of money you pay toward your care each year before your insurance starts paying for care).

Does my current health insurance status affect whether I can get VA health care benefits?

No. Whether or not you have health insurance coverage doesn’t affect the VA health care benefits you can get.

Note: It’s always a good idea to let your VA doctor know if you’re receiving care outside VA. This helps your provider coordinate your care to help keep you safe and make sure you’re getting care that’s proven to work and that meets your specific needs.
Flexible Spending Account (FSA)

Dependent Care FSA

The Dependent Care Flexible Spending Account allows you to set aside pre-tax dollars from your paycheck to pay for many healthcare and dependent care expenses. Paying for these expenses with pre-tax dollars reduces the amount of your taxable income. You may choose to participate in one or both FSAs.

In exchange for the tax advantages of your FSA, the IRS has imposed rules and restrictions for both healthcare and dependent care FSAs:

- Any money remaining in your FSAs at the end of the TANK plan year will be forfeited.
- If your employment terminates, only expenses incurred prior to termination will be eligible for reimbursement.
- You cannot begin, stop, or change the amount of your FSA contributions during the calendar year unless you experience a qualifying life event.
- You cannot claim expenses that are reimbursed through your FSA as a deduction on your income tax return.

Dependent Care FSA

- 100% Employee Paid
- Maximum Annual Contribution - $5,000
- There is no rollover provision available (Use It or Lose It). Any balance on December 31st is forfeited if expenses for Dependent Care are not incurred between January 1st and December 31st and submitted for reimbursement.
- This program allows you to pay for certain IRS-approved dependent daycare expenses with pre-tax dollars.

HealthCare FSA

The HealthCare Flexible Spending Account allows you to set aside pre-tax dollars from your paycheck to pay for qualified medical expenses. Paying for these expenses with pre-tax dollars reduces the amount of your taxable income. You may choose to participate in one or both FSAs.

If you are enrolled in Medicare or Veteran’s benefits you cannot contribute to a Health Savings Account (HSA). However, you can opt to contribute to a Flexible Spending Healthcare account.

HealthCare FSA

- 100% Employee Paid
- Maximum Annual Contribution – 2,650
- Any money remaining in your HealthCare FSA at the end of the TANK plan year will be forfeited with the exception of $500 that can be rolled over into the new plan year. (Your current plan year’s funds will be used first before any rollover funds from the previous year are used).
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<table>
<thead>
<tr>
<th>Health Savings Accounts (HSA)</th>
<th>Flexible Spending Accounts (FSA)</th>
<th>Health Reimbursement Arrangements (HRA)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overview</strong></td>
<td>A pre-tax employee or employer funded account that can be set up to reimburse employees for qualified medical expenses.</td>
<td>An employer funded account that reimburses employees for qualified medical care expenses. Employer may elect to include some or all medical expenses listed in IRC section 213(d).</td>
</tr>
<tr>
<td><strong>Who is eligible to set up an account?</strong></td>
<td></td>
<td>An employee whose employer offers one.</td>
</tr>
<tr>
<td>For 2018, any individual covered by a qualified high-deductible health plan (HDHP). (An HDHP with a $1,350 single/ $2,700 family minimum deductible).</td>
<td>An employee whose employer offers one.</td>
<td>An employee whose employer offers one.</td>
</tr>
<tr>
<td><strong>Who “owns” it?</strong></td>
<td>Employee.</td>
<td>Only the employer.</td>
</tr>
<tr>
<td>Individual/employee.</td>
<td>The employee, employer or both.</td>
<td></td>
</tr>
<tr>
<td><strong>Who may contribute to the account?</strong></td>
<td>The employee, employer or both.</td>
<td></td>
</tr>
<tr>
<td>The employee, employer or both.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>What are the limits on contributions?</strong></td>
<td>For 2018, employee contributions are limited to $2,650.</td>
<td>No federal income tax law limits. Employers typically “fund” the HRA at an amount that is half the deductible amount or less.</td>
</tr>
<tr>
<td>For 2018, a maximum of $3,450 for an individual account, $6,900 for a family account. The out-of-pocket limit in 2018 may not exceed $6,650 for an individual and $13,300 for a family.</td>
<td>For 2018, employee contributions are limited to $2,650.</td>
<td></td>
</tr>
<tr>
<td><strong>What is the tax treatment of contributions?</strong></td>
<td>Employee contributions are tax deductible. Employer contributions are excluded from gross income and not subject to employment taxes (e.g. FICA).</td>
<td>Employer’s contributions are generally excluded from employee’s gross income. However, an arrangement that distributes the unused HRA amount at termination either as a death benefit or as a severance payment will not qualify as an HRA. Employers receive expense deductions for payments.</td>
</tr>
<tr>
<td><strong>Is there a “catch up” contribution provision for older workers?</strong></td>
<td>Employees pay no federal, Social Security or (in most states) state taxes on FSA contributions.</td>
<td></td>
</tr>
<tr>
<td>For 2018, individuals age 55 or older may contribute an additional $1,000.</td>
<td>No available.</td>
<td></td>
</tr>
<tr>
<td><strong>Can funds be carried over from one year to the next?</strong></td>
<td>Yes. HSA funds may be carried over indefinitely during the individual’s lifetime.</td>
<td>* Yes. Unused amount in an HRA may be carried over, subject to any limits set by the employer.</td>
</tr>
<tr>
<td>* Maybe. Generally, unused FSA balances are forfeited at the end of the year. However, an FSA may be amended to either allow a grace period of up to 2½ months after the close of the plan year during which claims can be reimbursed with funds left over from the prior plan year— or amended to allow participants to rollover up to $500 in the next plan year. A plan may have either a grace period or a rollover, but not both.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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### 2018 COMPARISON OF HSAs, FSAs AND HRAs

<table>
<thead>
<tr>
<th>Health Savings Accounts (HSA)</th>
<th>Flexible Spending Accounts (FSA)</th>
<th>Health Reimbursement Arrangements (HRA)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Are accounts portable?</strong></td>
<td>Yes. Employees may take funds with them when they leave or change jobs.</td>
<td>No. Unused FSA balances are forfeited if the employee leaves or changes jobs unless COBRA or the plan’s grace period allow payment of claims incurred after termination.</td>
</tr>
<tr>
<td><strong>Does interest accrue on funds deposited in the account?</strong></td>
<td>Yes, interest and investment income accrue tax-free.</td>
<td>No, interest is not accrued.</td>
</tr>
<tr>
<td><strong>Which expenses are eligible?</strong></td>
<td>Otherwise unreimbursed medical expenses, as defined by IRC section 213(d) of the account holder, spouse, and tax dependents, other than insurance premiums (with limited exceptions for COBRA coverage, long-term care insurance, health insurance coverage while drawing unemployment compensation, and if 65 or older, any health insurance except a Medicare supplemental policy.)</td>
<td>Otherwise unreimbursed medical expenses as defined by IRC section 213(d) for the qualified medical expense of the account holder, spouse and biological, step or adopted child of the account holder up to the child’s 27th birthday. Cannot reimburse insurance premiums or qualified long-term care services.</td>
</tr>
<tr>
<td><strong>Can self-employed individuals, partners, or S-Corp owners participate?</strong></td>
<td>Yes, but generally only through the cafeteria plan of the employer on an after-tax basis.</td>
<td>No.</td>
</tr>
<tr>
<td><strong>Is discrimination testing required?</strong></td>
<td>If HSA contributions are made through a cafeteria plan, IRC section 125 nondiscrimination requirements apply. IRC section 105(h) nondiscrimination requirements do not apply.</td>
<td>IRC section 105(h) and IRC section 125 nondiscrimination requirements apply.</td>
</tr>
<tr>
<td><strong>Is it an employer sponsored plan subject to ERISA and COBRA?</strong></td>
<td>No.</td>
<td>Yes.</td>
</tr>
<tr>
<td><strong>How is money withdrawn?</strong></td>
<td>Check or debit card.</td>
<td>Check, direct deposit or debit card.</td>
</tr>
</tbody>
</table>
Wellness – NEW PROGRAM

TANK cares about your health and wants to provide you with resources to help you live better, both inside and outside of work. That’s why they offer a free voluntary wellness program for all employees that are enrolled in TANK’s medical plans. This program is administered by Wellworks for You. A packet will be provided to you with all the necessary information and required forms.

By completing the necessary steps, employees can earn reduced premiums for medical coverage.

1. Complete the Registration and Consent Form in its entirety and submit it to forms@wellworksforyou.com.

2. Complete an annual physical exam with your physician within 90 days of eligibility. Take your Wellworks packet with you to the appointment and have your doctor complete and sign the Physician Results Form. It is the participant’s responsibility to return the form as part of the completed packet.
   - Have you already received your annual preventive physical within the past 12 months? Take the packet to your physician’s office to have the Physician Results Form completed.
   - If you do not have a doctor, you can select a doctor from within the TANK benefit plan network. If you need assistance in finding a physician, please go to myuhc.com.

3. Sign and submit the Tobacco Affidavit.

4. Submit your completed packet within 90 days of eligibility. You can submit the packet in its entirety in one of three ways:
   - Scan and email to: forms@wellworksforyou.com
   - Secure fax to: 484-887-2223
   - Mail to: 1615 West Chester Pike, Suite 104, West Chester, PA 19382 (Attention: Forms Department)

Keep a copy of all forms for your files. You will be notified when your packet has been processed. Please allow 7-10 business days for processing.

NOTE: As a new hire with TANK, you will be enrolled with the Wellness premiums. If you do not complete the required elements of the Wellness program that includes getting your annual physical and turning in the required paperwork within 90 days of eligibility, you will be required to pay the Non-Wellness premiums and will be required to reimburse TANK for the difference between the Wellness and Non-Wellness premiums.

Questions: Please contact WellWorks for You at 800-425-4657.
Real Appeal – NEW!!

Introducing a new FREE weight loss program offered through United HealthCare for those that qualify with a body mass index (BMI) over 30 or overweight (BMI of 25 to 29.9). To enroll go to www.realappeal.com.

Weight issues in the U.S. have reached epidemic proportions. It’s estimated that nearly seven out of 10 adults (69 percent) are considered overweight or obese. UnitedHealthcare’s Real Appeal program can help you reverse this trend, with tools and support to help employees lose weight, feel good and prevent weight-related health conditions.

How it works

Real Appeal helps people make small changes necessary for larger long-term health results, based on weight-loss research studies commissioned by the National Institutes of Health. Real Appeal uses a highly interactive weekly internet show, videos and live online coaching to drive small behavior changes week by week over a full year. The program is designed to support members who are obese (body mass index (BMI) over 30), or overweight (BMI of 25 to 29.9).

Features

Expert coaching
- One-on-one coaching with a weight-loss expert
- Weekly group coaching and live online discussion

Personalized support
- Tools to help support success based on individualized needs:
  - Nutrition guides, meal plans, recipes, shopping lists and tips for dining out
  - Video workouts and fitness guides

Engaging entertainment
- Educational videos featuring popular celebrities and experts:
  - Samantha Harris — former Dancing with the Stars host
  - Dr. Ian Smith — co-host of The Doctors and correspondent for Rachael Ray
  - David Jack — recognized sports performance and conditioning coach
  - Ellie Krieger — host of the Food Network show, Healthy Appetite with Ellie Krieger
  - And more!

Tools and tracking
- Hands-on tools tailored to participant needs
- Online support tools, including educational website and digital applications
- Online or mobile tracking tools to monitor nutrition and exercise — such as changing moods, cravings, feelings of satiety, exercise and food intake
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With myuhc.com, you’ll have fewer questions and more confidence about your benefits, claims and health information. It’s personalized for you and simple to use. Take a few minutes to log onto myuhc.com to register.

Myuhc.com gives you practical, personalized information so you can:

• Understand your coverage
• Find a doctor in your area
• Manage your claims
• Organize your health information
• Estimate costs of future treatments
• Improve your health

Myuhc.com comes with your United HealthCare health plan.
myHealthcare Cost Estimator

United HealthCare also offers myHealthcare Cost Estimator that can be accessed from myuhc.com. This tool allows you to compare pricing for a procedure or look up a provider for a specific procedure. For example, if you are referred to have an MRI, you can check the cost at various locations (i.e., hospital versus a free-standing facility). The cost can vary from $400 to $1200 for the same procedure based on where you elect to have the test or procedure performed.

Be a smart consumer and do some research to save yourself some money.
Health4Me

Another app that is available is the Health4Me app. This tool is available to be downloaded free of charge from the App Store or Google Play. This app allows you to download your medical information to a smart device. You can contact member services directly from your smart device, pull up your health plan ID card, pull up myHealthcare Cost Estimator and much more.
Dental Plan

Dental health is an important part of your overall well-being. TANK provides you with a quality dental plan through Dental Care Plus. You must use an in-network provider to receive benefits, so you should always verify a provider is in-network prior to your appointment. Failure to use an in-network dentist will result in nothing being paid by Dental Care Plus.

Eligibility: Full time or Part time—after 60 days of employment


<table>
<thead>
<tr>
<th>DentalCarePlus-HMO</th>
<th>In-Network Only</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Deductible - Single/Family</td>
<td>$0/$0</td>
<td></td>
</tr>
<tr>
<td>Calendar Year Benefit Maximum</td>
<td></td>
<td>$1,000 per person</td>
</tr>
<tr>
<td>Preventive &amp; Diagnostic Care</td>
<td>Covered in Full</td>
<td></td>
</tr>
<tr>
<td>Basic Restorative Care (You Pay)</td>
<td>20% After Deductible</td>
<td></td>
</tr>
<tr>
<td>Major Restorative Care (You Pay)</td>
<td>50% After Deductible</td>
<td></td>
</tr>
<tr>
<td>Orthodontic Services- (You Pay)</td>
<td>50% After Deductible</td>
<td></td>
</tr>
<tr>
<td>Orthodontics (Limited to eligible dependent children under the age of 19)</td>
<td>$1,000 maximum per lifetime</td>
<td></td>
</tr>
</tbody>
</table>

**Weekly Premium Contributions**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Employee</strong></td>
<td>$5.94</td>
</tr>
<tr>
<td><strong>Employee + Spouse</strong></td>
<td>$12.81</td>
</tr>
<tr>
<td><strong>Employee &amp; Child(ren)</strong></td>
<td>$12.94</td>
</tr>
<tr>
<td><strong>Family</strong></td>
<td>$23.06</td>
</tr>
</tbody>
</table>

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In order to receive the highest level of benefits, you should always verify a provider is in-network prior to your appointment.

**Eligibility: Full time or Part time—after 60 days of employment**


<table>
<thead>
<tr>
<th>Vision Plan</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision Exam with Dilation (as necessary)</td>
<td>$10 Copay</td>
<td>Reimburse Up to $40.00</td>
</tr>
<tr>
<td>Frames</td>
<td>$130 Allowance, plus an additional 20% off balance over $130</td>
<td>Reimburse Up to $91.00</td>
</tr>
<tr>
<td><strong>Standard Plastic Lenses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single Vision Lenses</td>
<td>$15 Copay</td>
<td>Reimburse Up to $30.00</td>
</tr>
<tr>
<td>Bifocal Lenses</td>
<td>$15 Copay</td>
<td>Reimburse Up to $50.00</td>
</tr>
<tr>
<td>Trifocal Lenses</td>
<td>$15 Copay</td>
<td>Reimburse Up to $70.00</td>
</tr>
<tr>
<td><strong>Contact Lenses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conventional &amp; Disposable Medically Necessary</td>
<td>$130 Allowance $0 Copay</td>
<td>Reimburse Up to $130.00 Reimburse Up to $210.00</td>
</tr>
<tr>
<td><strong>Frequency of Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Examination Lenses or Contact Lenses Frames</td>
<td>12 months 12 months 24 months</td>
<td>12 months 12 months 24 months</td>
</tr>
<tr>
<td><strong>Premium Contributions</strong></td>
<td><strong>Weekly</strong></td>
<td></td>
</tr>
<tr>
<td>Employee</td>
<td>$1.45</td>
<td></td>
</tr>
<tr>
<td>Employee &amp; Spouse</td>
<td>$2.76</td>
<td></td>
</tr>
<tr>
<td>Employee &amp; Child(ren)</td>
<td>$2.90</td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td>$4.26</td>
<td></td>
</tr>
</tbody>
</table>
Employer Paid Life Insurance

Eligibility: after 6 months of employment

- Full time and Part time Collective Bargaining employees receive a $20,000 life insurance policy
- Full time Administrative employees receive 1 times their annual salary
- AD&D doubles the life insurance amount in case of an accident.

Employer Paid Basic Life and Accidental Death & Dismemberment (AD&D)

To aid in providing financial security for you and your family, TANK provides Basic Life Insurance and Basic Accidental Death and Dismemberment coverage for employees. You are automatically enrolled in these coverages.

Beneficiaries

A beneficiary is the person or persons you choose to receive these benefits. If you are married, but you do not choose to name your spouse as your beneficiary, you may be required to have him/her sign a waiver. If your beneficiary is a minor child, (under age 18), keep in mind that benefits may not be payable until they reach the age of 18.

You may also name a contingent beneficiary whose rights mature if the primary beneficiary predeceases the insured or dies before payment of the proceeds is completed. You are encouraged to seek the advice of a tax or investment professional when making this decision.

Remember to confirm your beneficiary designations at every open enrollment!
**Employer Paid Short and Long Term Disability**

Disability insurance is designed to cover a portion of your salary when you are unable to work due to an accident or illness. The unexpected could happen at any time. If you suddenly didn’t receive a paycheck, how would you pay your bills? It’s important to consider that sick and vacation time will only go so far.

**Short Term Disability Eligibility:**
**Full time Collective Bargaining Employees Only – after 6 months of employment.**

TANK provides eligible employees with Short Term Disability benefits at no cost to you. You are automatically enrolled in this coverage.

<table>
<thead>
<tr>
<th>Short-Term Disability</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Waiting Period</td>
<td>7 days Accident / 7 days Illness</td>
</tr>
<tr>
<td>Maximum Benefit Duration</td>
<td>26 weeks</td>
</tr>
</tbody>
</table>
| Weekly Maximum Benefit | $205 weeks 1 – 4  
$185 weeks 5 – 8  
$170 weeks 9 - 26 |

**Long Term Disability Eligibility:**
**Full time Administrative Employees Only – after 6 months of employment.**

TANK provides eligible employees with Long Term Disability benefits at no cost to you. You are automatically enrolled in this coverage.

<table>
<thead>
<tr>
<th>Long-Term Disability</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elimination Period</td>
<td>90 Days</td>
</tr>
<tr>
<td>Percentage of Income Replacement</td>
<td>60%</td>
</tr>
<tr>
<td>Weekly Maximum Benefit</td>
<td>$3,000/month</td>
</tr>
</tbody>
</table>
Employee Paid Voluntary Life Insurance

Eligibility: after 60 days of employment
- Part-time employees working at least 17.5 hours per week are eligible to enroll for Guardian voluntary life coverage.

You may purchase life insurance (in addition to the Basic Life coverage provided by TANK) on yourself in units of $10,000 to a maximum of $200,000.

You may also purchase life insurance for your dependent spouse and/or children. Dependent life insurance is available for your spouse in an amount equal to 50% of the employee’s covered amount to a maximum of $50,000. You may purchase coverage on your child(ren) age 14 days to 25 years (if a full-time student otherwise 23) in an amount equal to 10% of the employee’s covered amount to a maximum of $10,000.

Statement of Health (also known as Evidence of Insurability), is required when requesting a higher amount of coverage than is already in place, if enrolling after the time allowed for original enrollment as a new hire and if you elect coverage for you or your spouse in excess of the Guaranteed Issue limit. Guardian will provide notification to you directly regarding the approval or denial for the amounts of coverage requested.

As a new hire, you can elect up to the Guaranteed Issue amount without the need of completing a Statement of Health. If you request an amount of coverage that is higher than the Guaranteed Issue amount, you will automatically be enrolled in the amount up to the Guaranteed Issue amount, but will be required to complete a Statement of Health for the amount over the Guaranteed Issue. Guardian will provide notification to you directly regarding the approval or denial for the amount of coverage requested over the Guaranteed Issue amount.

Remember to designate a beneficiary. Once designated, if you decide you want to change the beneficiary, you can go to www.guardian.com to update your account.

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
</table>
| **Employee** | Available/Maximum Amount  
| | Available in $10,000 increments to a max of $200,000.  
| | Subject to Reduction Schedule based on age  
| | Guaranteed Issue: Ages 15-64 $100,000 / Ages 65-69 $10,000  
| **Spouse** | Available/Maximum Amount  
| | Available in $5,000 increments to a max of 50% of the Employee’s benefit up to $100,000.  
| | Subject to Reduction Schedule based on age  
| | Guaranteed Issue: Ages 15-65 $10,000 / Ages 65+ $5,000  
| **Child(ren)** | Available/Maximum Amount  
| | 10% of Employee’s benefit up to $10,000.  
| | Child age 14 days to age 23 (age 25 if full-time student)  

You must elect Optional Life coverage for yourself in order to cover your spouse and/or children.

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Voluntary Life Cost Illustration

<table>
<thead>
<tr>
<th>Policy Election Amount</th>
<th>30-34</th>
<th>35-39</th>
<th>40-44</th>
<th>45-49</th>
<th>50-54</th>
<th>55-59</th>
<th>60-64</th>
<th>65-69$^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>$10,000</td>
<td>.21</td>
<td>.23</td>
<td>.30</td>
<td>.49</td>
<td>.76</td>
<td>1.15</td>
<td>1.99</td>
<td>3.23</td>
</tr>
<tr>
<td>Employee</td>
<td>.21</td>
<td>.23</td>
<td>.30</td>
<td>.49</td>
<td>.76</td>
<td>1.15</td>
<td>1.99</td>
<td>3.23</td>
</tr>
<tr>
<td>Spouse</td>
<td>.10</td>
<td>.12</td>
<td>.15</td>
<td>.24</td>
<td>.38</td>
<td>.58</td>
<td>.99</td>
<td>1.62</td>
</tr>
<tr>
<td>Child</td>
<td>.04</td>
<td>.04</td>
<td>.04</td>
<td>.04</td>
<td>.04</td>
<td>.04</td>
<td>.04</td>
<td>.04</td>
</tr>
<tr>
<td>$20,000</td>
<td>.42</td>
<td>.46</td>
<td>.60</td>
<td>.97</td>
<td>1.52</td>
<td>2.31</td>
<td>3.97</td>
<td>6.46</td>
</tr>
<tr>
<td>Employee</td>
<td>.21</td>
<td>.23</td>
<td>.30</td>
<td>.49</td>
<td>.76</td>
<td>1.15</td>
<td>1.99</td>
<td>3.23</td>
</tr>
<tr>
<td>Spouse</td>
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This Benefits Guide has been prepared to help you review the key factors that are associated with our benefit plans. This Benefits Guide does not provide all of the contractual provisions, limitations or exclusions included in our policies and should be considered only as a summary of our current benefits. If any differences exist between this summary and the official contracts, the contracts shall prevail.
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### Voluntary Life Cost Illustration continued

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Employee Assistance Program (EAP)

www.stelizabeth.com
1-800-436-9300

Problems are just a part of everyday life. You and your household members now have access to an Employee Assistance Program (EAP) to help with the everyday challenges of life that may affect your health, family life and desire to excel at work. Through St. Elizabeth Healthcare, the EAP is an easy, completely confidential counseling and referral service that can help you, your family and household members deal with everyday personal or work related challenges—24 hours a day, 7 days a week, 365 days a year.

Consultation and Support

You and the members of your household have telephonic consultations available for maximum convenience and anonymity. Call 1-800-436-9300 anytime to speak with a clinician or schedule an appointment.

Work and Life Services

Telephonic consultations are available in the following areas:

- Marital Issues
- Relationship Issues
- Family Concerns
- Emotional Issues
- Grief and Loss
- Anxiety Problems
- Drug Use
- Child Behaviors
- Personal Growth
- Career Mapping
- Job Stress
- Alcohol Use
- Budgeting Help
- Legal Concerns
- Gambling Concerns
- Blending Family Issues
- Depression
- Aging Parents
- Parenting Concerns
- Retirement Planning
For other escalated benefit questions, please contact:
USI Benefit Resource Center (BRC)
Phone: 855-874-6699
BRCEast@usi.biz
Monday- Friday 8 AM to 5 PM EST
Retirement Benefits

Pension

Transit Authority of Northern Kentucky Disability and Retirement Allowance Plan is a defined benefit pension plan and is administered by the TANK Pension Committee.

Eligibility

- First of the month following 6 months of continuous service

Contributions

- TANK contributes to the plan
- Mandatory employee contribution
- Weekly payroll deduction

401K

401K is a supplement to the required pension plan

Eligibility

- First of the month following 6 months of continuous service

Contributions

- No company match
- Employee can contribute weekly through payroll deductions

Administrator

Kentucky Public Employees’ Deferred Compensation Authority located in Frankfort. www.kentuckydcp.com/1-800-542-4494
As an employee of TANK membership eligibility is open to you as well as your family members.

_C & O United Credit Union has been serving members since 1929. C & O has grown today into a full-service financial institution serving many diverse members and groups._

_We encourage you to take advantage of our services and to extend memberships to your family members as well._

To open an account with the credit union all that is required for membership is that you deposit $5.00 into a Savings (Share) Account, this is your primary account. Once opened it enables you to take advantage of all our other great services.

- Vacation Club
- Christmas Club
- Kids Club
- Checking Account (Debit Cards)
- Certificates of Deposit
- IRAs
- Borrowing Opportunities
  - Vehicles, Pre-approvals, Share Secured, Signature Loans, Home Equity, First Mortgage, Visa Cards
- Online Banking with Bill pay
- Plus; Money Orders, Visa Gift Cards, Free Notary Service, Drive-up Window, Financial Planning, Direct Deposits and Payroll Deductions

_Location – 3029 Dixie Highway, Edgewood, KY 41017
Phone number – (859) 331-3447, Fax (859) 578-3642
Web Site – www.co-united.org
Email – info@co-united.org
“SERVING MEMBERS FOR LIFE”_
BENEFIT SUMMARIES

Medical Plan Summaries are available upon request from Human Resources
Benefit Summary

TANK
HMO

Product: DHMO
Network: Dental Care Plus
Benefit Year: The 12 month period beginning January 1st and ending December 31st (calendar year)

Annual Maximum Benefit: $1000 per Member
Orthodontic Lifetime Maximum Benefit: $1000 per Eligible Member
Limited to eligible dependent children under age 19
Deductible: $0 per Member, per Benefit Year
$0 per Family, per Benefit Year

<table>
<thead>
<tr>
<th>Covered Dental</th>
<th>Deductible Applied</th>
<th>Percentage of Allowable Expense Paid by the Plan</th>
<th>Member Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Benefits</td>
<td>No</td>
<td>100%</td>
<td>None</td>
</tr>
<tr>
<td>Basic Benefits</td>
<td>No</td>
<td>80%</td>
<td>20%</td>
</tr>
<tr>
<td>Major Benefits</td>
<td>No</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Orthodontic Benefits</td>
<td>No</td>
<td>50% Limited to eligible dependent children under age 19</td>
<td>50%</td>
</tr>
</tbody>
</table>

Endodontic Services are covered as Basic Benefits.
Periodontic Services are covered as Basic Benefits.
Sealants are covered as Preventive Benefits.
Dependent children are eligible for coverage until age 26.

A complete description of benefits, limitations and exclusions are available in the Member Handbook. Members must receive services from a Dental Care Plus dentist.
## Vision Care

### Services

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network</th>
<th>Out of Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam With Dilation as Necessary</td>
<td>$10 Copay</td>
<td>Up to $40</td>
</tr>
<tr>
<td>Retinal Imaging</td>
<td>Up to $39</td>
<td>N/A</td>
</tr>
<tr>
<td>Frames</td>
<td>$0 Copay; $130 allowance, 20% off balance over $130</td>
<td>Up to $91</td>
</tr>
<tr>
<td>Standard Plastic Lenses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single Vision</td>
<td>$15 Copay</td>
<td>Up to $30</td>
</tr>
<tr>
<td>Bifocal</td>
<td>$15 Copay</td>
<td>Up to $50</td>
</tr>
<tr>
<td>Trifocal</td>
<td>$15 Copay</td>
<td>Up to $70</td>
</tr>
<tr>
<td>Lenticular</td>
<td>$15 Copay</td>
<td>Up to $70</td>
</tr>
<tr>
<td>Standard Progressive Lens</td>
<td>$80 Copay</td>
<td>Up to $50</td>
</tr>
<tr>
<td>Premium Progressive Lens</td>
<td>$100 Copay - $125 Copay</td>
<td>Up to $50</td>
</tr>
<tr>
<td>Tier 1</td>
<td>$100 Copay</td>
<td>Up to $50</td>
</tr>
<tr>
<td>Tier 2</td>
<td>$110 Copay</td>
<td>Up to $50</td>
</tr>
<tr>
<td>Tier 3</td>
<td>$125 Copay</td>
<td>Up to $50</td>
</tr>
<tr>
<td>Tier 4</td>
<td>$80 Copay, 20% off charge less $120 Allowance</td>
<td>Up to $50</td>
</tr>
<tr>
<td>Lens Options (paid by the member and added to the base price of the lens)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>UV Treatment</td>
<td>$15</td>
<td>N/A</td>
</tr>
<tr>
<td>Tint (Solid and Gradient)</td>
<td>$15</td>
<td>N/A</td>
</tr>
<tr>
<td>Standard Plastic Scratch Coating</td>
<td>$40</td>
<td>N/A</td>
</tr>
<tr>
<td>Standard Poly carbonate - age 19 and over</td>
<td>$40</td>
<td>N/A</td>
</tr>
<tr>
<td>Standard Poly carbonate - under age 19</td>
<td>$40</td>
<td>N/A</td>
</tr>
<tr>
<td>Standard Anti-Reflective Coating</td>
<td>$45</td>
<td>N/A</td>
</tr>
<tr>
<td>Premium Anti-Reflective Coating</td>
<td>$57 - $68</td>
<td>N/A</td>
</tr>
<tr>
<td>Tier 1</td>
<td>$57</td>
<td>N/A</td>
</tr>
<tr>
<td>Tier 2</td>
<td>$68</td>
<td>N/A</td>
</tr>
<tr>
<td>Tier 3</td>
<td>20% off Retail Price</td>
<td>N/A</td>
</tr>
<tr>
<td>Photochromic/Transitions</td>
<td>$75</td>
<td>N/A</td>
</tr>
<tr>
<td>Polarized</td>
<td>20% off Retail Price</td>
<td>N/A</td>
</tr>
<tr>
<td>Other Add-Ons and Services</td>
<td>20% off Retail Price</td>
<td>N/A</td>
</tr>
<tr>
<td>Contact Lens Fit and Follow-up</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standard Contact Lens Fit &amp; Follow-Up:</td>
<td>$40</td>
<td>N/A</td>
</tr>
<tr>
<td>Premium Contact Lens Fit &amp; Follow-Up:</td>
<td>10% off Retail Price</td>
<td>N/A</td>
</tr>
<tr>
<td>Contact Lenses (Contact Lens allowance includes materials only)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conventional</td>
<td>$0 copay, $130 allowance, 15% off balance over $130</td>
<td>Up to $130</td>
</tr>
<tr>
<td>Disposable</td>
<td>$0 copay, $130 allowance, plus balance over $130</td>
<td>Up to $130</td>
</tr>
<tr>
<td>Medically Necessary</td>
<td>$0 copay, Paid-In-Full</td>
<td>Up to $210</td>
</tr>
<tr>
<td>Laser Vision Correction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LASIK or PRK from U.S. LaserNetwork</td>
<td>15% off the retail price or 5% off the promotional price</td>
<td>N/A</td>
</tr>
<tr>
<td>Hearing Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing Health Care from Amplifon Hearing Network</td>
<td>40% off hearing exams and low price guarantee</td>
<td>N/A</td>
</tr>
<tr>
<td>Frequency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Examination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lenses (in lieu of contact lenses)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contacts (in lieu of lenses)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frame</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Lens Options (paid by the member and added to the base price of the lens)

- **UV Treatment**: $15
- **Tint (Solid and Gradient)**: $15
- **Standard Plastic Scratch Coating**: $40
- **Standard Poly carbonate - age 19 and over**: $40
- **Standard Poly carbonate - under age 19**: $40
- **Standard Anti-Reflective Coating**: $45
- **Premium Anti-Reflective Coating**: $57 - $68
- **Tier 1**: $57
- **Tier 2**: $68
- **Tier 3**: 20% off Retail Price
- **Photochromic/Transitions**: $75
- **Polarized**: 20% off Retail Price
- **Other Add-Ons and Services**: 20% off Retail Price

### Contact Lens Fit and Follow-up (Contact lens fit and two follow-up visits are available once a comprehensive eye exam has been completed.)

- **Standard Contact Lens Fit & Follow-Up**: $40
- **Premium Contact Lens Fit & Follow-Up**: 10% off Retail Price

### Contact Lenses (Contact Lens allowance includes materials only)

- **Conventional**: $0 copay, $130 allowance, 15% off balance over $130
- **Disposable**: $0 copay, $130 allowance, plus balance over $130
- **Medically Necessary**: $0 copay, Paid-In-Full

### Laser Vision Correction

- **LASIK or PRK from U.S. LaserNetwork**: 15% off the retail price or 5% off the promotional price

### Hearing Care

- **Hearing Health Care from Amplifon Hearing Network**: 40% off hearing exams and low price guarantee

### Frequency

- **Examination**: Once every 12 months
- **Lenses (in lieu of contact lenses)**: Once every 12 months
- **Contacts (in lieu of lenses)**: Once every 12 months
- **Frame**: Once every 24 months

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*4 Premium progressives and premium anti-reflective designs are subject to annual review by EyeMed’s Medical Director and are subject to change based on market conditions. Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. Benefits are not provided from services or materials arising from: 1) Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; 2) Medical and/or surgical treatment of the eye, eyes or supporting structures; 3) Any eye or Vision Examination, or any corrective eyewear required by a Policy Holder as a condition of employment; Safety eyewear; 4) Services provided as a result of any Workers’ Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; 5) plano (non-prescription) lenses; 6) non-prescription sunglasses; 7) Two pair of glasses in lieu of bifocals; 8) Services or materials provided by any other group benefit plan providing vision care 9) Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order. 10) Lost or broken frames, lenses, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available. Benefits may not be combined with any discount, promotional offering, or other group benefit plans. Standard/Premium Progressive lens not covered fund as a Bifocal lens. Standard Progressive lens covered fund Premium Progressive as a Standard. Benefit allowance provides no remaining balance for future use within the same benefit year. Fees charged for a non-insured benefit must be paid in full to the Provider. Such fees or materials are not covered.

Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, except in New York. Fidelity Security Life Policy number VC-19/VC-20, form number M-9083. This is a snapshot of your benefits. The Certificate of Insurance is
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 pages 9-16 for more details.
Important Legal Notices Affecting Your Health Plan Coverage

THE WOMEN’S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women’s Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

NEWBORNS ACT DISCLOSURE - FEDERAL

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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents’ other coverage). However, you must request enrollment within 30 days after your or your dependents’ other coverage ends (or after the employer stops contributing toward the other coverage).

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. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact person listed at the end of this summary.
NOTICE REGARDING WELLNESS PROGRAMS

Wellworks 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. You will also be asked to complete a biometric screening and physical to participate in the wellness program.

However, employees who choose to participate in the wellness program will receive an incentive of reduced medical premiums. Although you are not required to get a physical or participate in the biometric screening, only employees who do so will receive the wellness rate discount.

The results from your biometric screening will 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 Transit Authority of Northern Kentucky may use aggregate information it collects to design a program based on identified health risks in the workplace, Wellworks 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. The only individual(s) who will receive your personally identifiable health information is a healthy coach or physician in order to provide you with services under the wellness program.

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 your human resources department at 859-814-2139.

WELLNESS PROGRAM DISCLOSURE

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact
us and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

### STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (“ERISA”). ERISA provides that all participants shall be entitled to:

#### Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator’s office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.
- Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan’s annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

#### Continue Group Health Plan Coverage

If applicable, you may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.

#### Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for operation of the Plan. These people, called “fiduciaries” of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants.

No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

#### Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $149 per day (up to a $1,496 cap per request), until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

#### Assistance with your Questions

If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.
CONTACT INFORMATION

Questions regarding any of this information can be directed to:
Renae Agramonte
3375 Madison Pike
Fort Wright, KY 41017
859-814-2139
ragramonte@tankbus.org

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

Your Information. Your Rights. Our Responsibilities.
Recipients of the notice are encouraged to read the entire notice. Contact information for questions or complaints is available at the end of the notice.

Your Rights
You have the right to:
• Get a copy of your health and claims records
• Correct your health and claims records
• Request confidential communication
• Ask us to limit the information we share
• Get a list of those with whom we’ve shared your information
• Get a copy of this privacy notice
• Choose someone to act for you
• File a complaint if you believe your privacy rights have been violated

Your Choices
You have some choices in the way that we use and share information as we:
• Answer coverage questions from your family and friends
• Provide disaster relief
• Market our services and sell your information

Our Uses and Disclosures
We may use and share your information as we:
• Help manage the health care treatment you receive
• Run our organization
• Pay for your health services
• Administer your health plan
• Help with public health and safety issues
• Do research
• Comply with the law
• Respond to organ and tissue donation requests and work with a medical examiner or funeral director
• Address workers’ compensation, law enforcement, and other government requests
• Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records
• You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
• We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records
• You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
• We may say “no” to your request, but we’ll tell you why in writing, usually within 60 days.

Request confidential communications
• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
• We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share
• You can ask us not to use or share certain health information for treatment, payment, or our operations.
• We are not required to agree to your request.

Get a list of those with whom we’ve shared information
• You can ask for a list (accounting) of the times we’ve shared your health information for up to six years prior to the date you ask, who we shared it with, and why.
• We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
• We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices
For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation
  If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
In these cases we never share your information unless you give us written permission:
- Marketing purposes
- Sale of your information

Our Uses and Disclosures
How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive
We can use your health information and share it with professionals who are treating you.
Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Pay for your health services
We can use and disclose your health information as we pay for your health services.
Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan
We may disclose your health information to your health plan sponsor for plan administration.
Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Run our organization
- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.
Example: We use health information about you to develop better services for you.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone’s health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers’ compensation, law enforcement, and other government requests
We can use or share health information about you:
- For workers’ compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

**Changes to the Terms of this Notice**

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our website (if applicable), and we will mail a copy to you.

**Other Instructions for Notice**

- Effective Date: January 1, 2018
- Renae Agramonte / HR Manager
  
  ragramonte@tankbus.org
  
  859-814-2139

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**Important Notice from Transit Authority of Northern Kentucky About Your 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 Transit Authority of Northern Kentucky 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. **Transit Authority of Northern Kentucky has determined that the prescription drug coverage offered by the United Healthcare Insurance Company 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 15th to December 7th.

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 Transit Authority of Northern Kentucky coverage will not be affected. You can keep this coverage and it will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current Transit Authority of Northern Kentucky coverage, be aware that you and your dependents will be able to get this coverage back (during open enrollment or in the case of a special enrollment opportunity).

**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 Transit Authority of Northern Kentucky 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 person listed below for further. 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 Transit Authority of Northern Kentucky 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: January 1, 2018
Name of Entity/Sender: Transit Authority of Northern Kentucky
Contact--Position/Office: Renae Agramonte / HR Manager
Address: 3375 Madison Pike
Phone Number: 859-814-2139
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 August 10, 2017. Contact your State for more information on eligibility –

<table>
<thead>
<tr>
<th>State</th>
<th>Program</th>
<th>Website</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALABAMA – Medicaid</td>
<td>Website: <a href="http://myalhipp.com">http://myalhipp.com</a></td>
<td>Phone: 1-855-692-5447</td>
<td></td>
</tr>
<tr>
<td>FLORIDA – Medicaid</td>
<td>Website: <a href="http://flmedicaidtplrecovery.com/hipp">http://flmedicaidtplrecovery.com/hipp</a></td>
<td>Phone: 1-877-357-3268</td>
<td></td>
</tr>
<tr>
<td>ALASKA – Medicaid</td>
<td>Website: <a href="http://myakhipp.com">http://myakhipp.com</a></td>
<td>Phone: 1-866-251-4861 Email: <a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a> Medicaid Eligibility: <a href="http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx">http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx</a></td>
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<tr>
<td>GEORGIA – Medicaid</td>
<td>Website: <a href="http://dch.georgia.gov/medicaid">http://dch.georgia.gov/medicaid</a></td>
<td>Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507</td>
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<tr>
<td>ARKANSAS – Medicaid</td>
<td>Website: <a href="http://myarhipp.com">http://myarhipp.com</a></td>
<td>Phone: 1-855-MyARHIPP (855-692-7447)</td>
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<tr>
<td>INDIANA – Medicaid</td>
<td>Healthy Indiana Plan for low-income adults 19-64 Website: <a href="http://www.in.gov/fsa/hip">http://www.in.gov/fsa/hip</a> Phone: 1-877-438-4479 All other Medicaid Website: <a href="http://www.indianamedicaid.com">http://www.indianamedicaid.com</a> Phone 1-800-403-0864</td>
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<tr>
<td>State</td>
<td>Program</td>
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<tr>
<td>Kansas</td>
<td>Medicaid</td>
<td><a href="http://www.kdheks.gov/hcf/">http://www.kdheks.gov/hcf/</a></td>
<td>1-785-296-3512</td>
</tr>
<tr>
<td>Kentucky</td>
<td>Medicaid</td>
<td><a href="http://chfs.ky.gov/dms/default.htm">http://chfs.ky.gov/dms/default.htm</a></td>
<td>1-800-635-2570</td>
</tr>
<tr>
<td>New Jersey</td>
<td>Medicaid and CHIP</td>
<td><a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a></td>
<td>609-631-2392</td>
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<tr>
<td></td>
<td></td>
<td><a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a></td>
<td>1-800-701-0710</td>
</tr>
<tr>
<td>Louisiana</td>
<td>Medicaid</td>
<td><a href="http://dhhlouisiana.gov/index.cfm/subhome/1/n/331">http://dhhlouisiana.gov/index.cfm/subhome/1/n/331</a></td>
<td>1-888-695-2447</td>
</tr>
<tr>
<td>New York</td>
<td>Medicaid</td>
<td><a href="https://www.health.ny.gov/health_care/medicaid/">https://www.health.ny.gov/health_care/medicaid/</a></td>
<td>1-800-541-2831</td>
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<td>TTY: Maine relay 711</td>
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<tr>
<td>Massachusetts</td>
<td>Medicaid and CHIP</td>
<td><a href="http://www.mass.gov/eohhs/gov/departments/masshealth/">http://www.mass.gov/eohhs/gov/departments/masshealth/</a></td>
<td>1-800-462-1120</td>
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<td><a href="http://www.myhealthplanma.com">http://www.myhealthplanma.com</a></td>
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<td><a href="http://www.oregonhealthcare.gov/index-es.html">http://www.oregonhealthcare.gov/index-es.html</a></td>
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<tr>
<td>Missouri</td>
<td>Medicaid</td>
<td><a href="http://mn.gov/dhs/people-we-serve/seniors/healthcare/health-care/programs-and-services/medical-assistance.jsp">http://mn.gov/dhs/people-we-serve/seniors/healthcare/health-care/programs-and-services/medical-assistance.jsp</a></td>
<td>1-800-657-3739</td>
</tr>
<tr>
<td>North Carolina</td>
<td>Medicaid</td>
<td><a href="https://dma.ncdhhs.gov/">https://dma.ncdhhs.gov/</a></td>
<td>919-855-4100</td>
</tr>
<tr>
<td>Minnesota</td>
<td>Medicaid</td>
<td><a href="http://www.mn.gov/dhs/medicalassistance/hc.jsp">http://www.mn.gov/dhs/medicalassistance/hc.jsp</a></td>
<td>1-800-675-3799</td>
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<td><a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a></td>
<td>573-751-2005</td>
</tr>
<tr>
<td>Montana</td>
<td>Medicaid</td>
<td><a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPPP">http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPPP</a></td>
<td>1-800-694-3084</td>
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<tr>
<td></td>
<td></td>
<td><a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a></td>
<td>1-888-365-3742</td>
</tr>
<tr>
<td>Nebraska</td>
<td>Medicaid</td>
<td><a href="http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm">http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm</a></td>
<td>1-800-692-7462</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>Medicaid</td>
<td><a href="http://www.eohhs.ri.gov/">http://www.eohhs.ri.gov/</a></td>
<td>401-462-5300</td>
</tr>
<tr>
<td>Nevada</td>
<td>Medicaid</td>
<td><a href="https://dwss.nv.gov/">https://dwss.nv.gov/</a></td>
<td>1-800-992-0900</td>
</tr>
<tr>
<td>South Carolina</td>
<td>Medicaid</td>
<td><a href="https://www.scdhhs.gov">https://www.scdhhs.gov</a></td>
<td>1-888-549-0820</td>
</tr>
</tbody>
</table>

**Medicaid Website:**
- [http://chfs.ky.gov/dms/default.htm](http://chfs.ky.gov/dms/default.htm)
- [http://www.state.nj.us/humanservices/dmahs/clients/medicaid/](http://www.state.nj.us/humanservices/dmahs/clients/medicaid/)
- [http://www.njfamilycare.org/index.html](http://www.njfamilycare.org/index.html)
- [http://dhhlouisiana.gov/index.cfm/subhome/1/n/331](http://dhhlouisiana.gov/index.cfm/subhome/1/n/331)
- [https://dma.ncdhhs.gov/](https://dma.ncdhhs.gov/)
- [http://www.myhealthplanma.com](http://www.myhealthplanma.com)
- [http://www.oregonhealthcare.gov/index-es.html](http://www.oregonhealthcare.gov/index-es.html)
- [http://www.dss.mo.gov/mhd/participants/pages/hipp.htm](http://www.dss.mo.gov/mhd/participants/pages/hipp.htm)
- [http://www.mn.gov/dhs/medicalassistance/hc.jsp](http://www.mn.gov/dhs/medicalassistance/hc.jsp)
- [http://www.dhhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm](http://www.dhhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm)
- [http://www.eohhs.ri.gov/](http://www.eohhs.ri.gov/)
- [https://dwss.nv.gov/](https://dwss.nv.gov/)
- [https://www.scdhhs.gov](https://www.scdhhs.gov)
<table>
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<tr>
<th>SOUTH DAKOTA - Medicaid</th>
<th>WASHINGTON – Medicaid</th>
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<tr>
<td>Website: <a href="http://dss.sd.gov">http://dss.sd.gov</a></td>
<td>Website: <a href="http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program">http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program</a></td>
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<tr>
<td>Phone: 1-888-828-0059</td>
<td>Phone: 1-800-562-3022 ext. 15473</td>
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<thead>
<tr>
<th>TEXAS – Medicaid</th>
<th>WEST VIRGINIA – Medicaid</th>
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<tr>
<td>Website: <a href="http://gethipptexas.com/">http://gethipptexas.com/</a></td>
<td>Website: <a href="http://mywhipp.com/">http://mywhipp.com/</a></td>
</tr>
<tr>
<td>Phone: 1-800-440-0493</td>
<td>Toll-free Phone: 1-855-MyWVHI PP (1-855-699-8447)</td>
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<tr>
<th>UTAH – Medicaid and CHIP</th>
<th>WISCONSIN – Medicaid and CHIP</th>
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<tbody>
<tr>
<td>Medicaid Website: <a href="https://medicaid.utah.gov/">https://medicaid.utah.gov/</a></td>
<td>Website: <a href="https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf">https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf</a></td>
</tr>
<tr>
<td>CHIP Website: <a href="http://health.utah.gov/chip">http://health.utah.gov/chip</a></td>
<td>Phone: 1-800-362-3002</td>
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<tr>
<td>Phone: 1-877-543-7669</td>
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<tr>
<th>VERMONT – Medicaid</th>
<th>WYOMING – Medicaid</th>
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<tr>
<td>Website: <a href="http://www.greenmountaincare.org/">http://www.greenmountaincare.org/</a></td>
<td>Website: <a href="https://wye">https://wye</a> qualitycare.acs-inc.com/</td>
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<tr>
<td>Phone: 1-800-250-8427</td>
<td>Phone: 307-777-7531</td>
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| VIRGINIA – Medicaid and CHIP | |
|-----------------------------| |
| Medicaid Website: http://www.coverva.org/programsPremium_assistance.cfm | |
| Medicaid Phone: 1-800-432-5924 | |
| CHIP Website: http://www.coverva.org/programsPremium_assistance.cfm | |
| CHIP Phone: 1-855-242-8282 | |

To see if any other states have added a premium assistance program since August 10, 2017, 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 12/31/2019)
PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by 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. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you’re eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer’s health plan. However, you may be eligible for a tax 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 meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.1

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer–offered coverage. Also, this employer contribution –as well as your employee contribution to employer–offered coverage– is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after–tax basis.

How Can I Get More Information?
For more information about your coverage offered by your employer, please check your summary plan description or the HR department.

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.

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1 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.
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.

<table>
<thead>
<tr>
<th>3. Employer name</th>
<th>4. Employer Identification Number (EIN)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transit Authority of Northern Kentucky</td>
<td>61-0734529</td>
</tr>
<tr>
<td>5. Employer address</td>
<td>6. Employer phone number</td>
</tr>
<tr>
<td>3375 Madison Pike</td>
<td>859-814-2139</td>
</tr>
<tr>
<td>7. City</td>
<td>8. State</td>
</tr>
<tr>
<td>Fort Wright</td>
<td>KY</td>
</tr>
</tbody>
</table>

10. Who can we contact about employee health coverage at this job?
    Renae Agramonte

11. Phone number (if different from above) | 12. Email address |
<table>
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<tbody>
<tr>
<td></td>
<td><a href="mailto:ragramonte@tankbus.org">ragramonte@tankbus.org</a></td>
</tr>
</tbody>
</table>

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:

- With respect to dependents:
  - [x] We do offer coverage. Eligible dependents are:
    - Your Spouse and Dependent Children to age 26
  - [ ] We do not offer coverage.

- [x] 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.

- 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)