Hancock
the signature county of Ohio

RISK strategies
first insurance group

Employee Benefits
Enrollment Guide

myBenefits

RISK strategies
first insurance group

Welcome
to your benefits enrollment

Hancock County offers you and your eligible family members a comprehensive and valuable benefits program. We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family.

All of the employees of Hancock County are encouraged to contact First Insurance Group during the year for service, support and general information about your benefits.

First Insurance Team Contacts:

Benefits Account Executive: Lori Huth, 419-436-7632, lhuth@risk-strategies.com

Customer Service Team: 1-833-936-1179 FIG-BenefitService@risk-strategies.com

Benefits Consultant: Ben Otley, 419-354-2734, botley@risk-strategies.com

Hours: 8:00 a.m. – 4:30 p.m. Monday – Friday

firstinsurancegrp.com

Medical + Prescription Drug Plan 1

Insurance Carrier	Anthem BCBS
Policy Name	PPO Plan
Policy #	W51059
Website:	www.anthem.com
Customer Service	1-855-603-7982

Medical + Prescription Drug Plan 2

Insurance Carrier	Anthem BCBS
Policy Name	HSA Plan
Policy #	W51059
Website:	www.anthem.com
Customer Service	1-855-603-7982

Dental

Insurance Carrier	Delta Dental
Policy Name	Deltal Dental PPO
Policy #	9917
Website:	www.deltadental.com
Customer Service	1-800-524-0149

Life

Insurance Carrier	Anthem Life
Policy Name	Basic Life/AD&D
Policy #	CM10002221
Website:	www.anthem.com
Customer Service	1-800-552-2137

Vision

Insurance Carrier	Vision Service Plan
Policy Name	VSP Signature
Policy #	12254792
Website:	www.vsp.com
Customer Service	1-800-877-7195

Who is eligible?

If you are a full-time employee (working 30 or more hours per week), you, your spouse and your dependent children are eligible to enroll in the benefits described in this guide.

How to enroll.

The first step is to review the available benefit options and complete applications for selected benefits. Once you have made your elections, you will not be able to change them until the next open enrollment period unless you have a qualified change in status.

When to enroll.

As a new employee, most of your benefits will be effective on the 1st day of the month following your employment. Applications for requested benefits should be returned to your Supervisor prior to effective date.

How to make changes.

Unless you have a qualified change in status, you cannot make changes to the benefits you elect until the next open enrollment period; held in November for a January 1 effective date. Qualified changes in status include: marriage, divorce, legal separation, death of a spouse, child or other qualified dependent, change in residence due to an employment transfer for you or your spouse, commencement or termination of adoption proceedings, or change in spouse's benefits or employment status.

Available
Employee Benefits

- Medical
- Dental
- Vision
- Employer-Paid Life
- Health Savings Account
- Flexible Spending Account

Employee Contributions

EMPLOYEE PER PAY DEDUCTIONS (24 PAYS) – ANTHEM MEDICAL PPO 1F AND DELTA DENTAL		
	Employee Only	Employee & Family
	$64.72	$171.26

EMPLOYEE PER PAY DEDUCTIONS (24 PAYS) – ANTHEM MEDICAL HSA 3 AND DELTA DENTAL		
	Employee Only	Employee & Family
	$14.06	$37.24

EMPLOYEE PER PAY DEDUCTIONS (MONTHLY) – VSP VISION			
	Employee Only	Employee & Spouse Employee & 1 Child	Employee & Children Employee & Family
	$2.42	$6.72	$17.81

Required Forms
and Applications

Hancock
the signature county of Ohio

If making changes, you must complete a CEBCO form in addition to this Election Form

2024 Coverage Election Form

Employee Information:			
Name (Last, First, Middle Initial)	Social Security#		Date of Birth
Address	City	State	Zip Code

MEDICAL/PRESCRIPTION - Anthem/CEBCO PPO 1F and DENTAL - Delta (Eligibility - 30+ hours) ***Please check the appropriate box.**			**Medical/Prescription/ Dental PPO 1F**
	Employee Contribution Per Pay (24 Pays)		
Employee Only	$64.72	☐	Pre-Tax ☐
Family	$171.26	☐	

MEDICAL/PRESCRIPTION - Anthem/CEBCO HSA E2 and DENTAL - Delta (Eligibility - 30+ hours) ***Please check the appropriate box.**			**Medical/Prescription/ Dental HSA E2**
	Employee Contribution Per Pay (24 Pays)		
Employee Only	$14.06	☐	Pre-Tax ☐
Family	$37.24	☐	
Waiving Coverage	$0	☐	☐

Vision - VSP (Eligibility - 30+ hours) ***Please check the appropriate box.**			**Vision**
		Employee Contribution Per Month	
Employee Only		$2.42	☐ Pre-Tax ☐
Employee & Spouse **or** 1 Child	Employee &	$6.72	☐
Employee & Children **or**	Family	$17.81	☐
Waiving Coverage		$0	☐ ☐

Health Savings Account Payroll Deduction Authorization (ONLY IF YOU ELECTED THE HSA E2 PLAN) I authorize the reduction of my salary on a per paycheck basis, by the amount designated below. I understand that deductions cannot be remitted to my Health Savings Account until I have completed the HSA Application and the account has been opened by the Bank.		**Health Savings Account**
Employee Contribution Per Pay (24 Pays) $_____	Employee Contribution Per Year $_____	
The IRS has established annual limits that can be contributed to Health Savings Accounts. The maximum amount that can be deposited into your account is $4,150 for single coverage and $8,300 for family coverage for the 2024 calendar year. The catch-up provision allows participants age 55 and older to deposit an additional $1,000 for 2024.		$ Pre-Tax Deduction

☐ My initials certify that I am making **NO CHANGES** to my current plans or dependents.

I certify that I have carefully reviewed the employee benefits available to me and authorize payroll deductions based on the elections outlined in this form. Pretax deductions reduce the salary used to calculate my Social Security benefit at retirement. I understand that, without a qualified change in my status, I am unable to make changes to my elections until our next open enrollment with an effective date of January 1, 2024.

I further certify that I have received the following notices regarding Hancock County employee benefit plan offerings.

- Summary of Benefits and Coverage (SBC)
- Newborns' and Mothers' Protection Act
- HIPAA Privacy Notice
- Marketplace Notice
- CMS Part D Creditable Coverage Notice
- Genetic Information Non-discrimination Act
- Women's Health and Cancer Rights Act
- Children's Health Insurance Program
- Special Enrollment Notice

Signature:_____ Date:_____

HANCOCK COUNTY DECLARATION OF ELIGIBILITY FOR HSA CONTRIBUTION

Name: _____

Department: _____

I acknowledge that I have been offered the opportunity to purchase health insurance from Hancock County for myself and my dependents. Varying factors allow or disallow contributions to a Health Savings Account (HSA) for Medicare, Medicaid, Tricare, secondary coverage, veterans' medical benefits from the VA.

Please mark <u>ALL</u> boxes that apply:

I accept enrollment in the HSA at this time:

☐ I do not have Medicare, Medicaid, Tricare, secondary coverage in my spouse's or parents medical plan that is not an HSA-compatible health plan or veterans' medical benefits from the VA.

I understand that it is my responsibility to notify the payroll administrator to stop my HSA contribution if I choose to participate in a secondary insurance.

☐ I am a veteran who has not received veterans' medical benefits from the VA in the previous three months that did not consist solely of disregarded coverage, preventive care, hospital care or medical services under any law administered by the Secretary of Veterans Affairs for service-connected disability. I am eligible for the HSA contribution from Hancock County and accept the HSA contribution.

I understand that it is my responsibility to notify the payroll administrator to stop my HSA contribution for three months if I am a veteran who received veterans' medical benefits from the VA that did not consist solely of disregarded coverage, preventive care, hospital care or medical services under any law administered by the Secretary of Veterans Affairs for service-connected disability.

☐ I am not claimed as a dependent on someone else's taxes.

☐ I am not covered by a Health Reimbursement Account.

☐ I am electing coverage in the High Deductible Health Plan, but declining to open an HSA account at this time.

I attest that the above information provided is true and accurate. I understand that Hancock County is not responsible for usage of my HSA account and that it is my responsibility to follow IRS rules and procedures. I will indemnify Hancock County for any expenses or penalties incurred by the County as a result of my misuse.

Employee Signature: _____Date: _____

Please contact Lori Huth from First Insurance Group at 419-436-7632 for all other questions pertaining to HSA eligibility.

Cafeteria/Flex Plan Enrollment Form

Company Name (Employer)

Employee Information

First Name	Last Name	Middle Initial
SSN	Date of Birth	Email *(required)*
Address	City	State/Zip

Enrollment Information

☐ New ☐ Renewal | Effective Date | First Payroll Deduction Date

Unreimbursed Medical

Annual amount of Unreimbursed Medical $	Annual employer contribution (if offered) $
Please check the one that applies to your situation	☐ Regular Flex Plan ☐ Limited Purpose Flex Plan (If you or your Spouse have an HSA.)

Dependent Care

Annual election for dependent care $	Annual employer contribution (if offered) $

Authorization: I certify the above information to be true to the best of my knowledge and that the children on whom I will be claim- ing dependent expenses or child care either reside with me in a parent child relationship or are legally dependent on me for their support. I agree to have my compensation reduced by the deduction amount(s) stated above. I understand that any amounts remaining in my account(s) not used for qualified expenses incurred during the plan year will be forfeited in accordance with current plan provisions and tax laws. I further understand that the Flexible Compensation deduction(s) will be in effect for the entire plan year and cannot be revoked unless I experience a change in my family status or termination of employment.

Signature | Date

I decline to participate in the Flex Spending account

Signature | Date

Direct Deposit

If you are new to enrolling in the flex plan and are interested in signing up for direct deposit, please log in to the consumer portal https://kabelparticipant.lh1ondemand.com after the start of the new plan year. If you have already provided iSolved with direct deposit information in the past, there will be nothing further needed and we will continue to send your reimbursements as direct deposit. You can also update your banking information in the consumer portal.

Medical Benefits

effective on first of the month following date of employment

Anthem

County Employee Benefit Consortium of Ohio
CEBCO
Health & Wellness

County Employee Benefit Consortium of Ohio
CEBCO
Health & Wellness

Get the Support You Need!

PROGRAM	RESOURCE	ELIGIBLE	CONTACT
Anthem Member Services	Medical	Members enrolled in medical plan.	855-603-7982
Anthem Rx	Prescription Drug	Members enrolled in prescription drug plan.	833-930-1772
Anthem Rx Mail Order	Prescription Drug Mail Order	Members wishing to participate in the mail order program.	833-236-6196
Anthem Rx Specialty	Prescription Drug Specialty Drug	Members enrolled in the prescription drug program and are prescribed a specialty medication.	833-255-0645
Sydney Health	Smart Phone App	Members enrolled in medical plan age 18+; provides access to all CEBCO benefits and programs.	Download the app to use; 866-755-2680
SmartShopper	Save Money on Healthcare Procedures	Members enrolled in medical plan.	Smartshopper.com 866-488-5441
LiveHealth Online Medical	Telephonic/Video Doctor Visit	Members enrolled in the medical plan who are not feeling well can talk with a doctor by going to www.livehealthonline.com	888-548-3432
LiveHealth Online Psychology	Telephonic/Video Counseling	Members enrolled in the medical plan who are having a tough time can talk with a counselor by going to www.livehealthonline.com	888-548-3432
ComPsych	EAP	Employees and their household members; access to a behavioral health professional, 5 face to face counseling sessions per issue, and unlimited phone support for financial, legal, and lifestyle issues; no charge.	877-327-4452
HealthWorks	Wellness Program	Employees and their spouses enrolled in the medical plan may complete this voluntary program annually; participation is free of charge. Incentives vary by county/employer.	513-751-1288
Nurse Line Anthem	24/7 Nurse Assist	Members enrolled in medical plan can speak with a nurse at any time with medical questions; no charge.	888-249-3820
ConditionCare Anthem	Disease Management	Members enrolled in medical plan with Asthma, COPD, Coronary Artery Disease, Diabetes, or Heart Failure; no charge.	888-249-3820
Future Moms Anthem	Prenatal	Members enrolled in medical plan who are expecting; no charge.	888-249-3820
Tobacco Cessation	Quit Line	Members enrolled in medical plan age 18 or older; one on one phone coaching plus 8 weeks of nicotine replacement therapy; no charge.	800-QUIT-NOW

Anthem® Blue Cross and Blue Shield

Your Plan: Hancock County PPO Plan 1F Rx 1F Plan Year: 2024

Your Network: Blue Access

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$500 person / $1,000 family	$1,000 person / $2,000 family
Overall Out-of-Pocket Limit	$3,000 person / $6,000 family	$6,000 person / $12,000 family
The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per person deductible or per person out-of-pocket limit. All medical deductibles, copayments and coinsurance apply toward the out-of-pocket limit(s) (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services). In-Network and Non-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.		
Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP).*		
Medical Chats and Virtual Visits for Primary Care *from our Online Provider K Health, available through Sydney Health are covered at $0 copay per visit medical deductible does not apply.*		
Virtual Visits from online provider LiveHealth Online *for urgent/acute medical and mental health and substance abuse care available through Sydney Health or via www.livehealthonline.com are covered at $0 copay per visit medical deductible does not apply.*		
Primary Care (PCP) and Mental Health and Substance Abuse Care *virtual and office*	$20 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Specialist Care *virtual and office*	$40 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	$20 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Manipulation Therapy *Coverage is limited to 12 visits per benefit period.*	$40 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Other Services in an Office		
Allergy Testing *When Allergy injections are billed separately by network providers, the member is responsible for a $5 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Prescription Drugs *Dispensed in the office*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Surgery	$40 copay per visit medical deductible does not apply‡	40% coinsurance after medical deductible is met
Preventive care / screenings / immunizations	No charge	40% coinsurance after medical deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	40% coinsurance after medical deductible is met
Diagnostic Services **Lab**		
Office	No charge	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
X-Ray		
Office	No charge	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Emergency and Urgent Care		
Urgent Care *includes doctor services. Additional charges may apply depending on the care provided.*	$75 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	$300 copay per visit and 0% coinsurance medical deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services	0% coinsurance medical deductible does not apply	Covered as In-Network
Ambulance	20% coinsurance after medical deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Abuse Care at a Facility		
Facility Fees	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Doctor Services	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Doctor and Other Services		
Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<u>Hospital (Including Maternity, Mental Health and Substance Abuse)</u>		
Facility Fees	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Human Organ and Tissue Transplants *Cornea transplants are treated the same as any other illness and subject to the medical benefits.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Physician and other services *including surgeon fees*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Home Health Care *Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.* *Coverage for occupational therapy is limited to 30 visits per benefit period, physical therapy is limited to 30 visits per benefit period and speech therapy is limited to 20 visits per benefit period.*		
Office	$40 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Pulmonary rehabilitation *Coverage is limited to 20 visits per benefit period.*		
Office	$40 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Cardiac rehabilitation *Coverage is limited to 36 visits per benefit period.*		
Office	$40 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Dialysis/Hemodialysis		
Office	$40 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Chemo/Radiation Therapy		
Office	$40 copay per visit medical deductible does not apply‡	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Skilled Nursing Care (facility) *Coverage for Skilled Nursing and Inpatient Rehabilitation facility (includes services in an outpatient day rehabilitation program) is limited to 90 days combined per benefit period.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Inpatient Hospice	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Durable Medical Equipment	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Out-of-Pocket Limit	$2,500 Person $5,000 Family	Not applicable
Prescription Drug Coverage **Network:** Base Network **Drug List: National** *Drugs not included on the drug list will not be covered.*		
Day Supply Limits: **Retail Pharmacy** *30 day supply (cost shares noted below)* **Rx Maintenance 90 Pharmacy** *90 day supply (after 2 courtesy 30-day fills you will be required to purchase maintenance medications in 90-day fills at a M90 pharmacy or home delivery).* **Home Delivery Pharmacy** *90 day supply (maximum cost shares noted below) Maintenance medications are available through CarelonRx Mail (IngenioRx will become CarelonRx on January 1, 2023). You will need to call us on the number on your ID card to sign up when you first use the service.* **Specialty Pharmacy** *30 day supply (cost shares noted below for retail and home delivery apply). We require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy. Drug cost share assistance programs may be available for certain specialty drugs.*		
Tier 1 - Typically Generic	$10 copay per prescription (retail) and $20 copay per prescription (home delivery)	Not applicable
Tier 2 – Typically Preferred Brand	$20 copay per prescription (retail) and $40 copay per prescription (home delivery)	Not applicable
Tier 3 - Typically Non-Preferred Brand	$40 copay per prescription (retail) and $80 copay per prescription (home delivery)	Not applicable
Specialty Medications (brand and generic)	$40 copay per prescription	No coverage

Notes:

- Dependent age: to end of the month in which the child attains age 26.
- Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help the member know if the services are considered not medically necessary.
- No charge means no deductible/copayment/coinsurance up to the maximum allowable amount. 20% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- The Primary Care Physician and Specialist office visit copay applies to both office and facility based office visits for evaluation and management services only.

CEBCO - Anthem® Blue Cross and Blue Shield

Your Plan: Hancock County HSA E2 Plan Year: 2024

Your Network: Blue Access

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$3,200 person / $6,400 family	$6,400 person / $12,800 family
Overall Out-of-Pocket Limit	$5,000 person / $10,000 family	$10,000 person / $20,000 family
The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per person deductible or per person out-of-pocket limit. All medical deductibles, copayments and coinsurance apply toward the out-of-pocket limit(s) (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services). In-Network and Non-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.		
Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP).*		
Medical Chats and Virtual Visits for Primary Care *from our Online Provider K Health, available through Sydney Health ($39 for urgent/acute medical and $99 for preventive care services per visit before deductible), then 0% coinsurance after deductible is met.*		
Virtual Visits from online provider LiveHealth Online *for urgent/acute medical ($54 per visit) and mental health and substance abuse care are available through Sydney Health or via www.livehealthonline.com are covered at 0% coinsurance after deductible is met.*		
Primary Care (PCP) and Mental Health and Substance Abuse Care *virtual and office*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Specialist Care *virtual and office*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Manipulation Therapy *Coverage is limited to 12 visits per benefit period.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Other Services in an Office		
Allergy Testing	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Prescription Drugs *Dispensed in the office*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Surgery	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Preventive care / screenings / immunizations	No charge	40% coinsurance after deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	40% coinsurance after deductible is met
Diagnostic Services **Lab**		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
X-Ray		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Emergency Room Facility Services	20% coinsurance after deductible is met	Covered as In-Network

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Emergency Room Doctor and Other Services	20% coinsurance after deductible is met	Covered as In-Network
Ambulance	20% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Abuse Care at a Facility		
Facility Fees	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Doctor Services	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Doctor and Other Services		
Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Hospital (Including Maternity, Mental Health and Substance Abuse)		
Facility Fees	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Human Organ and Tissue Transplants *Cornea transplants are treated the same as any other illness and subject to the medical benefits.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Physician and other services *including surgeon fees*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Home Health Care *Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.* *Coverage for occupational therapy is limited to 30 visits per benefit period, physical therapy is limited to 30 visits per benefit period and speech therapy is limited to 20 visits per benefit period.*		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pulmonary rehabilitation *office and outpatient hospital* *Coverage is limited to 20 visits per benefit period.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Cardiac rehabilitation *office and outpatient hospital* *Coverage is limited to 36 visits per benefit period.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Dialysis/Hemodialysis *office and outpatient hospital*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Chemo/Radiation Therapy *office and outpatient hospital*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Skilled Nursing Care (facility) *Coverage for Skilled Nursing and Inpatient Rehabilitation facility (includes services in an outpatient day rehabilitation program) is limited to 100 days combined per benefit period.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Inpatient Hospice	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Durable Medical Equipment	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	Combined with In-Network medical deductible	Combined with Non-Network medical deductible
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with Non-Network medical out-of-pocket limit
Prescription Drug Coverage **Network:** ***Base Network*** **Drug List: National** *Drugs not included on the drug list will not be covered.*		
Day Supply Limits: **Retail Pharmacy** *30 day supply (cost shares noted below)* **Rx Maintenance 90 Pharmacy** *90 day supply (after 2 courtesy 30-day fills you will be required to purchase maintenance medications in 90-day fills at a M90 pharmacy or home delivery)*		

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Home Delivery Pharmacy *90 day supply (maximum cost shares noted below) Maintenance medications are available through CarelonRx Mail (IngenioRx will become CarelonRx on January 1, 2023). You will need to call us on the number on your ID card to sign up when you first use the service.* **Specialty Pharmacy** *30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy. Drug cost share assistance programs may be available for certain specialty drugs.*		
Tier 1 - Typically Generic	20% coinsurance after deductible is met (retail and home delivery)	Not applicable
Tier 2 – Typically Preferred Brand	20% coinsurance after deductible is met (retail and home delivery)	Not applicable
Tier 3 - Typically Non-Preferred Brand	20% coinsurance after deductible is met (retail and home delivery)	Not applicable
Specialty Medications (brand and generic)	20% coinsurance after deductible is met (retail and home delivery)	No coverage

Notes:

- Dependent age: to end of the month in which the child attains age 26.
- Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help the member know if the services are considered not medically necessary.
- No charge means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services".
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- Ohio's House Bill 388 and the Federal No Surprises Act establish patient protections including from Out-of-Network Providers' surprise bills ("balance billing") for Emergency Care and other specified items or services. We will comply with these new state and federal requirements including how we process claims from certain Out-of-Network Providers.

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

Health Savings Account

hsabank
own your health.

Group Online Enrollment Instructions

In just three easy steps you can enroll in a Health Savings Account (HSA) using HSA Bank's Group Online Enrollment System.

Step 1 Type or copy and paste this customized link into your Internet browser https://secure.hsabank.com/group_enrollment/enrollment.aspx?id=346400608 You will be directed to an enrollment page created specifically for your group. Enter your Social Security Number or Tax Payer Identification Number and click Submit.

Step 2 Complete the online enrollment application.

Step 3 Sign up for Internet Banking to take advantage of the many benefits, including: 24/7 access to your account, up to the minute account activity and balance information, electronic statements, tax documents, email notifications and electronic funds transfer.

Please note: After completion, your account will typically open in 1-2 business days. Your employer can check your enrollment status through HSA Bank's Employer Site. A welcome kit with important account information will be mailed to you in approximately 7-10 business days after your account is opened. Please review it carefully in order to optimize your HSA benefits.

2024 County Contribution Single:

- $35/month
- Additional $100/month matched to employee contribution

2024 County Contribution Family:

- $90/month
- Additional $200/month matched to employee contribution

For assistance, please contact Client Assistance Center
(800) 357-6246 Monday – Friday, 8 a.m. – 10 p.m., EST
www.hsabank.com
605 N. 8th Street, Ste. 320, Sheboygan, WI 53081

How to use your HSA

An HSA from HSA Bank doesn't just make it easy to save money on your healthcare expenses — it makes it easy to manage your account, too.

Manage your account online

Sign up to access your account balances, transaction history, and statements, as well as track your expenses.

1. **HSA Bank Mobile App** – Download to check available balances, view HSA transaction details, save and store receipts, scan items in-store to see if they're qualified, and access customer service contact information.

2. **myHealth Portfolio℠** – Track your healthcare expenses, manage receipts and claims from multiple providers, and view expenses by provider, description, and more.

3. **Account preferences** – Designate a beneficiary, add an authorized signer, order additional debit cards, and keep important information up to date.

Deposit funds into your HSA

To maximize tax and savings benefits, fund your HSA as soon as you can. There are a few convenient ways to contribute.

- **Payroll deduction** – Money is deducted from your paychecks, pre-tax, and transferred to your HSA. Talk to your employer to sign up.
- **Online transfer** – Visit the Member Website to transfer funds from your personal checking or savings account to your HSA.
- **Check** – Mail your personal check and completed contribution form found on the Member Website to: HSA Bank, PO Box 939, Sheboygan, WI 53082

Pay for healthcare expenses

Whether you want to reimburse yourself for an IRS-qualified medical expense paid out of pocket or pay directly from your HSA, there are a few ways to get your funds.[1]

NOTE: Transactions are limited to your available cash balance.

- **HSA Bank Health Benefits Debit Card** – Access your HSA funds when you use your debit card at qualified merchants or ATMs for withdrawals.[2] You can add your debit card to your mobile wallet using Apple Pay or Samsung Pay.
- **Online transfer** – Visit the Member Website or use the mobile app to reimburse yourself for out-of-pocket expenses. Schedule a one-time or recurring online transfer from your HSA to your personal checking or savings account.
- **Online bill pay** – Use this feature to pay medical providers directly from your HSA.

[1] You can use your HSA to pay for a wide range of IRS-qualified medical expenses, including many that aren't typically covered by health insurance plans. This includes deductibles, co-insurance, prescriptions, dental and vision care, and more. Go to **irs.gov** or **hsabank.com/QME** for a list of IRS-qualified medical expenses.

[2] HSA Bank has set daily limits on debit card transactions for fraud protection. These limits are listed in your Health Savings Account Custodial Agreement.

Visit **hsabank.com** or call the number on the back of your debit card for more information.

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A Division of Webster Bank, N.A., Member FDIC

HSA, HRA, Healthcare FSA and Dependent Care Eligibility List

The following is a summary of common expenses claimed against Health Savings Accounts (HSAs), Health Reimbursement Arrangements (HRAs), Healthcare Flexible Spending Accounts (HC-FSAs) and Dependent Care Flexible Spending Accounts (DC-FSAs). Due to frequent updates to the regulations governing these accounts and arrangements, this list does not guarantee reimbursement and is to be utilized as a guide for the submission of claims. For a full list of IRS-qualified medical expenses, please review IRS Publication 502.

If you have an HRA, your employer's plan may only reimburse a subset of expenses. Please refer to your Plan Document for confirmation of reimbursable expenses under your plan.

If you are currently participating in a High Deductible Health Plan (HDHP) and are contributing to an HSA, you may also participate in a Limited Purpose HRA or Health FSA. Expenses are limited to dental and vision expenses identified with an * in the list below.

Common IRS-qualified medical expenses

Acupuncture
Ambulance
Artificial limbs
Artificial teeth*
Birth control treatment
Blood sugar test kits for diabetics
Breast pumps and lactation supplies
Chiropractor
Contact lenses and solutions*
Crutches
Dental treatments
(including X-rays, cleanings, fillings, sealants, braces and tooth removals*)
Doctor's office visits and co-pays
Drug addiction treatment
Drug prescriptions
Eyeglasses (Rx and reading)*
Fluoride treatments*
Flu shots
Guide dogs
Hearing aids and batteries
Infertility treatment
Inpatient alcoholism treatment
Insulin
Laboratory fees
Laser eye surgery*
Medical alert bracelet
Medical records charges
Midwife
Occlusal guards to prevent teeth grinding
Orthodontics*
Orthotic Inserts (custom or off the shelf)
Over-the-counter medicines and drugs, if prescribed by a doctor
(see more information below)
Physical therapy
Special education services for learning disabilities (recommended by a doctor)
Speech therapy
Stop-smoking programs
(including nicotine gum or patches, if prescribed)
Surgery, excluding cosmetic surgery
Vaccines
Vasectomy
Vision exam*
Walker, cane
Wheelchair

Common over-the-counter (OTC) medicines (requiring a prescription)

Examples include, but are not limited to:

Acid controllers
Acne medicine
Aids for indigestion
Allergy and sinus medicine
Anti-diarrheal medicine
Baby rash ointment
Cold and flu medicine
Eye drops*
Feminine antifungal or anti-itch products
Hemorrhoid treatment
Laxatives or stool softeners
Lice treatments
Motion sickness medicines
Nasal sprays or drops
Ointments for cuts, burns or rashes
Pain relievers, such as aspirin or ibuprofen
Sleep aids
Stomach remedies

Services that may be eligible with a Letter of Medical Necessity completed

This list is not all-inclusive:

- Weight-loss program
  - only if it is a treatment for a specific disease diagnosed by a physician (e.g., obesity, hypertension, heart disease)
- Compression hosiery/socks, anti-embolism socks or hose
- Massage treatment for specific ailment or diagnosis
- CPR classes for adult or child
- Improvements or special equipment added to a home or other capital expenditures for a physically handicapped person

Ineligible expenses

Listed below are some services and expenses that are not eligible for reimbursement. This list is not all-inclusive:

- Aromatherapy
- Baby bottles and cups
- Baby oil
- Baby wipes
- Breast enhancement
- Cosmetics and skin care
- Cotton swabs
- Dental floss
- Deodorants
- Hair re-growth supplies and/or services
- Health club membership dues
- Humidifier
- Lotion
- Low-calorie foods
- Mouthwash
- Petroleum jelly
- Shampoo and conditioner
- Spa salts

Eligible dependent care expenses

- Au pair services
- Babysitting services
- Before- and after-school programs
- Custodial or eldercare expenses, in-home or daycare center (not medical care)
- Nursery school
- Pre-kindergarten
- Summer day camp
  - (not educational in nature)

Ineligible dependent care expenses

- Clothing
- Food/meals
- Kindergarten and higher education/tuition expenses
- Overnight camp

This list is not comprehensive. It is provided to you with the understanding that HSA Bank is not engaged in rendering tax advice. The information provided is not intended to be used to avoid federal tax penalties. For more detailed information, please refer to IRS Publication 502 titled, "Medical and Dental Expenses," Catalog Number 15002Q. Publications can be ordered directly from the IRS by calling 1-800-TAXFORM. If tax advice is required, you should seek the services of a professional.

Please call the number on the back of your HSA Bank debit card or visit us at www.hsabank.com

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own your health.

Expense_Eligibility_112717_FL-10439

Dental Benefits

effective on first of the month following date of employment

DELTA DENTAL®

County Employee Benefit Consortium of Ohio
CEBCO
Health & Wellness

DELTA DENTAL®

County Employee Benefit Consortium of Ohio CEBCO Health & Wellness

Delta Dental PPO™ (Point-of-Service)
Summary of Dental Plan Benefits
For Group# 9917-4800, 4810, 4811, 4812, 4813, 4814, 4815, 4816, 4818, 4819, 4820, 4825, 4829, 4830, 4831, 4837, 4840, 4842, 4844, 4865, 4867, 4880, 4899
County Employee Benefits Consortium of Ohio, Inc.
Hancock County

This Summary of Dental Plan Benefits should be read along with your Certificate. Your Certificate provides additional information about your Delta Dental plan, including information about plan exclusions and limitations. If a statement in this Summary conflicts with a statement in the Certificate, the statement in this Summary applies to you and you should ignore the conflicting statement in the Certificate. The percentages below are applied to Delta Dental's allowance for each service and it may vary due to the dentist's network participation.*

Control Plan – Delta Dental of Ohio

Benefit Year – January 1 through December 31

Covered Services –

	Delta Dental PPO™ Dentist	Delta Dental Premier® Dentist	Nonparticipating Dentist
	Plan Pays	Plan Pays	Plan Pays*
Diagnostic & Preventive			
Diagnostic and Preventive Services – exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Emergency Palliative Treatment – to temporarily relieve pain	100%	100%	100%
Sealants – to prevent decay of permanent teeth	100%	100%	100%
Brush Biopsy – to detect oral cancer	100%	100%	100%
Radiographs – X-rays	100%	100%	100%
Basic Services			
Minor Restorative Services – fillings and crown repair	80%	80%	80%
Endodontic Services – root canals	80%	80%	80%
Periodontic Services – to treat gum disease	80%	80%	80%
Oral Surgery Services – extractions and dental surgery	80%	80%	80%
Other Basic Services – misc. services	80%	80%	80%
Relines and Repairs – to prosthetic appliances	80%	80%	80%
Major Services			
Major Restorative Services – crowns	50%	50%	50%
Prosthodontic Services – bridges, implants, dentures, and crowns over implants	50%	50%	50%
Orthodontic Services			
Orthodontic Services – braces	50%	50%	50%
Orthodontic Age Limit –	No Age Limit	No Age Limit	No Age Limit

* When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. This amount may be less than what the Dentist charges or Delta Dental approves and you are responsible for that difference.

- Oral exams (including evaluations by a specialist) are payable twice per calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment.
- Fluoride treatments are payable twice per calendar year for people age 18 and under.
- Bitewing X-rays are payable once per calendar year and full mouth X-rays (which include bitewing X-rays) or a panorex are payable once in any five-year period.
- Sealants are payable once per tooth per lifetime for first permanent molars for people age eight and under and second permanent molars for people age 13 and under. The surface must be free from decay and restorations.
- Composite resin (white) restorations are payable on posterior teeth.
- Porcelain and resin facings on crowns are optional treatment on posterior teeth.

- Implants are payable once per tooth in any five-year period. Implant related services are Covered Services.
- Crowns over implants are payable once per tooth in any five-year period. Services related to crowns over implants are Covered Services.
- People with special health care needs may be eligible for additional services including exams, hygiene visits, dental case management, and sedation/anesthesia. Special health care needs include any physical, developmental, mental, sensory, behavioral, cognitive, or emotional impairment or limiting condition that requires medical management, healthcare intervention, and/or use of specialized services or programs. The condition may be congenital, developmental, or acquired through disease, trauma, or environmental cause and may impose limitations in performing daily self-maintenance activities or substantial limitations in major life activity.

Having Delta Dental coverage makes it easy for you to get dental care almost everywhere in the world! You can now receive expert dental care when you are outside of the United States through our Passport Dental program. This program gives you access to a worldwide network of dentists and dental clinics. English-speaking operators are available around the clock to answer questions and help you schedule care. For more information, check our Web site or contact your benefits representative to get a copy of our Passport Dental information sheet.

Maximum Payment – $1,000 per Member total per Benefit Year on all services except orthodontic services. $1,000 per Member total per lifetime on orthodontic services.

Payment for Orthodontic Service – When orthodontic treatment begins, your Dentist will submit a payment plan to Delta Dental based upon your projected course of treatment. In accordance with the agreed upon payment plan, Delta Dental will make an initial payment to you or your Participating Dentist equal to Delta Dental's stated Copayment on 30% of the Maximum Payment for Orthodontic Services as set forth in this Summary of Dental Plan Benefits. Delta Dental will make additional payments as follows: Delta Dental will pay 50% of the per monthly fee charged by your Dentist based upon the agreed upon payment plan provided by Delta Dental to your Dentist.

Deductible – $50 Deductible per Member total per Benefit Year limited to a maximum Deductible of $150 per family per Benefit Year. The Deductible does not apply to diagnostic and preventive services, emergency palliative treatment, brush biopsy, X-rays, sealants, and orthodontic services.

Waiting Period – Enrollees who are eligible for Benefits are covered on the first day of the month following the date of hire.

Eligible People – All full-time employees of Hancock County: Common Pleas Court (4800), Commissioners (4810), Juvenile Court (4811), Probate Court (4812), Clerk of Courts (4813), Coroner (4814), Emergency Management Agency (4815), Board of Elections (4816), Sheriff (4818), Recorder (4819), Auditor (4820), Veterans (4825), Public Defenders (4829), Treasurer (4830), Engineers (4831), Board of Health (4837), Prosecuting Attorney (4840), Mental Health - ADAMHS (4842), Job & Family Services (4844), Regional Planning Commission (4865), Soil & Water Conservation (4867), and Data Center - IT Dept. (4880) working at least 30 hours per week, grandfathered part-time employees, and COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) enrollees (4899).

Also eligible are your Spouse and your Children to the end of the month in which they turn 26, including your Children who are married, who no longer live with you, who are not your Dependents for Federal income tax purposes, and/or who are not permanently disabled.

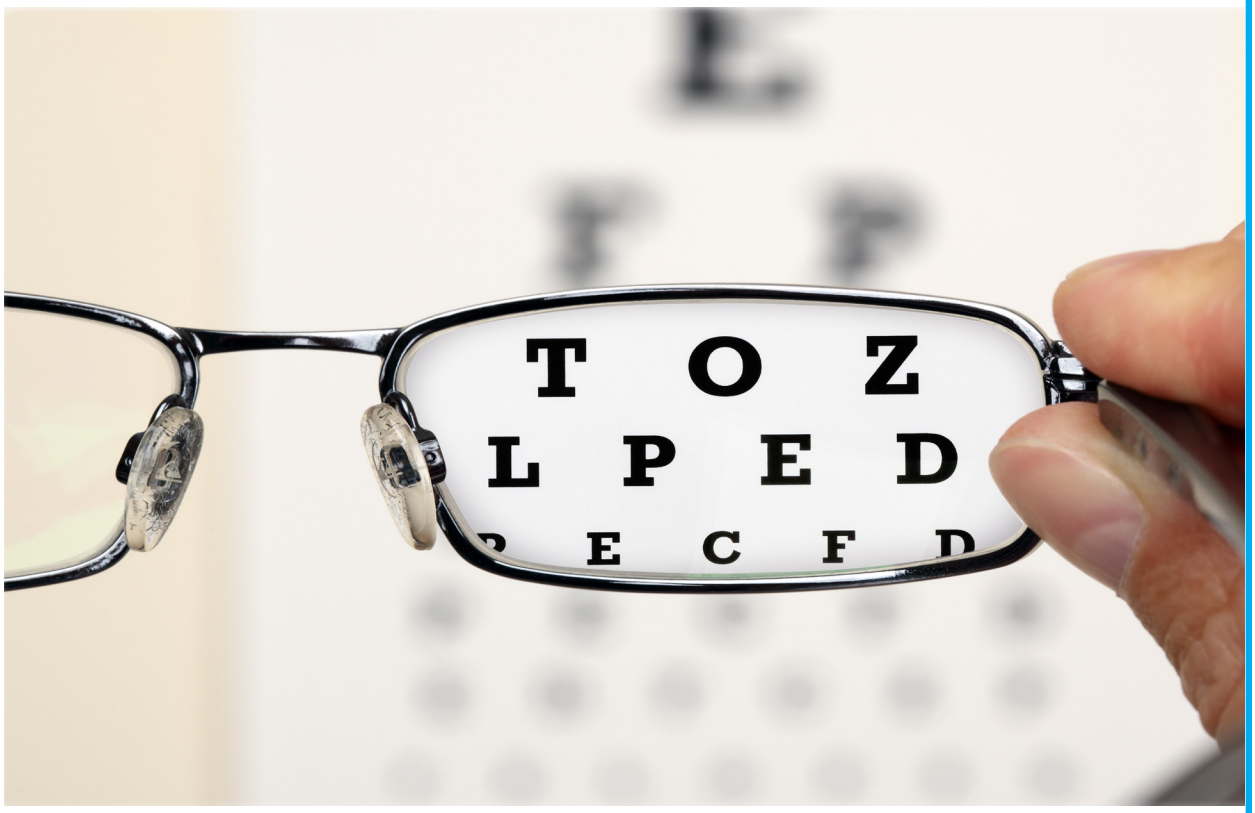
Dependents choosing this plan are required to remain enrolled for a period of 12 months. Should a Dependent choose to drop coverage after that time, he or she may not re-enroll prior to the date on which 12 months have elapsed. An election may be revoked or changed at any time if the change is the result of a qualifying event as defined under Internal Revenue Code Section 125.

Coordination of Benefits – If you and your Spouse are both eligible to enroll in This Plan as Enrollees, you may be enrolled together on one application or separately on individual applications, but not both. Your Dependent Children may be enrolled on one application. Delta Dental will not coordinate Benefits between your coverage and your Spouse's coverage if you and your Spouse are both covered as Enrollees under This Plan.

Benefits will cease on the last day of the month in which your employment is terminated.

Vision Benefits

effective on first of the month following date of employment



vsp vision care

County Employee Benefit Consortium of Ohio
CEBCO
Health & Wellness

A Look at Your VSP Vision Coverage

With VSP and COUNTY EMPLOYEE BENEFIT CONSORTIUM OF OHIO (CEBCO-PLAN 6), your health comes first.

As a member, you'll get access to savings and personalized vision care from a VSP network doctor for you and your family.

vsp vision care

Value and savings you love.

Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras which provide offers from VSP and leading industry brands totaling over $3,000 in savings.

Provider choices you want.

vsp PREMIER PROGRAM

Maximize your benefits at a Premier Program location, which is part of our incredible network of doctors.

Shop online and connect your benefits.

eyeconic a vsp vision company

Eyeconic® is the preferred VSP online retailer where you can shop in-network with your vision benefits. See your savings in real time when you shop over 70 brands of contacts, eyeglasses, and sunglasses.

Quality vision care you need.

You'll get great care from a VSP network doctor, including a WellVision Exam®. An annual eye exam not only helps you see well, but helps a doctor detect signs of eye conditions and health conditions, like diabetes and high blood pressure.

Using your benefit is easy!

Create an account on **vsp.com** to view your in-network coverage, find the VSP network doctor who's right for you, and discover savings with Exclusive Member Extras. At your appointment, just tell them you have VSP.

More Ways to Save

Extra

$20

to spend on Featured Brands†

bebe · CALVIN KLEIN · COLE HAAN · DRAGON · FLEXON · LACOSTE · and more

See all brands and offers at **vsp.com/offers**.

+

Up to

40%

Savings on lens enhancements‡

Create an account today.

Contact us: **800.877.7195** or **vsp.com**

Your VSP Vision Benefits Summary

COUNTY EMPLOYEE BENEFIT CONSORTIUM OF OHIO (CEBCO-PLAN 6) and VSP provide you with an affordable vision plan.

PROVIDER NETWORK:
VSP Signature
EFFECTIVE DATE:
01/01/2023

vsp vision care

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
Your Coverage with a VSP Provider			
WELLVISION EXAM	• Focuses on your eyes and overall wellness	$10	Every 12 months
ESSENTIAL MEDICAL EYE CARE	• Retinal screening for members with diabetes • Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. • Coordination with your medical coverage may apply. Ask your VSP doctor for details.	$0 per screening $20 per exam	Available as needed
PRESCRIPTION GLASSES		**$25**	
FRAME[+]	• $140 featured frame brands allowance • $120 frame allowance • 20% savings on the amount over your allowance	Included in Prescription Glasses	Every 12 months
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	Included in Prescription Glasses	Every 12 months
LENS ENHANCEMENTS	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 40% on other lens enhancements	$0 $80 - $90 $120 - $160	Every 12 months
CONTACTS (INSTEAD OF GLASSES)	• $120 allowance for contacts and contact lens exam (fitting and evaluation) • 15% savings on a contact lens exam (fitting and evaluation)	$0	Every 12 months
EXTRA SAVINGS	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to **vsp.com/offers** for details. • 30% savings on additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% from any VSP provider within 12 months of your last WellVision Exam.		
	Routine Retinal Screening • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam		
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities • After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor		

YOUR COVERAGE GOES FURTHER IN-NETWORK

With so many in-network choices, VSP makes it easy to get the most out of your benefits. You'll have access to preferred private practice, retail, and online in-network choices. Log in to **vsp.com** to find an in-network provider. Your plan provides the following out-of-network reimbursements:

Exam ..... up to $50	Lined Bifocal Lenses ..... up to $75	Progressive Lenses ..... up to $75
Frame ..... up to $70	Lined Trifocal Lenses ..... up to $100	Contacts ..... up to $105
Single Vision Lenses ..... up to $50		

†Only available to VSP members with applicable plan benefits. Frame brands and promotions are subject to change.
‡Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details.
+Coverage with a retail chain may be different or not apply.

VSP guarantees member satisfaction from VSP providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business. TruHearing is not available directly from VSP in the states of California and Washington.

Life Benefits

effective on first of the month following employment

Hancock County provides a $50,000 Life and Accidental Death & Dismemberment Policy at no additional cost to Sheriffs Department employees subject to a collective bargaining agreement. All other full- time employees working 30 or more hours per week are provided a $10,000 Life and Accidental Death & Dismemberment Policy at no additional cost.

Anthem

County Employee Benefit Consortium of Ohio
CEBCO
Health & Wellness

Flexible Spending Account

isolved Benefit Services

isolved Benefit Services

Dear Employees:

We are excited to administer a great benefit that your company is offering to its employees. It's called a Section 125 Cafeteria Plan or Flexible Benefits Plan. By using the Flexible Spending Account (FSA) available through the plan, you can save a great deal of money. The savings is achieved by not paying taxes on the amount you put into your account for health care and dependent care expenses.

Your Flexible Benefits Plan includes three components:

Health Care Spending Account – pre-tax dollars set aside to cover out-of-pocket medical expenses not covered by your plan.

Dependent Care Spending Account – pre-tax dollars that can be used to pay for day care for tax dependents.

Premium Conversion – allows you to have your benefit premiums deducted pretax from payroll.

Here's how it works. Each payroll, your company places the amount you designate from your pay into your personal health and/or dependent care spending accounts. The money – which is put aside without being taxed – is earmarked for out-of-pocket expenses. Those expenses might include your day care bill, a co-pay for a visit to the doctor or a prescription.

The money you can save by using your FSA can be significant. For example, Employee A earns $1,700 per month. She elects to place $60 in her Health FSA, $260 in her Dependent Care FSA and also has her $50 health plan contribution taken out before tax each month. By taking care of these necessary expenses on a pre-tax basis, she could save over $100 in taxes per month, money she will surely be happy to spend elsewhere. Every employee's situation is a little different, but there is a reason this plan is called a Flexible Benefits Plan. It can be used to suit your needs and will save you money.

Participation is easy. Just review the enrollment materials provided for all the rules, calculate your expenses to determine your annual election, fill out the enrollment form and start saving.

If you have questions about your plan, please contact your HR representative.

isolved Benefit Services

FSA worksheet

Estimated unreimbursed health care expenses

Medical	Annual amount
Deductible	
Coinsureance payment	
Contraceptives	
Doctor's office visits	
Immunizations	
Insulin	
Laboratory tests	
Other expenses	
Over-the-counter medicine[1]	
Physicals/annual checkups	
Prescription drugs	
Splints, supports, Corrective devices	
Therapy treatments (medical reasons only)	
Well-baby care	
Subtotal	

Dental	Annual amount
Deductible	
Coinsureance payment	
Cleaning dentures	
Fillings/crowns/bridges	
Fluoride treatments	
Orthodontia (medical reasons only)	
X-rays	
Subtotal	

Vision	Annual amount
Deductible	
Coinsureance payment	
Contact lenses and solutions	
Examinations	
Frames	
Laser eye surgery	
Lenses	
Subtotal	
Total	

Dependent Day Care (necessary for you and your spouse to work)	Annual amount
After-school care	
Care of other dependents	
Child care/ day care center	
Child care in home	
Preschool	
Total[2]	

Unreimbursed health care expenses cannot exceed your plan's maximum.

NOTE: any coordination of benefits with another group plan may reduce your out-of-pocket expenses.

[1]Effective January 1, 2020, the passage of the CARES Act (COVID-3 Stimulus Bill) reinstated over-the-counter medicines as an eligible reimbursement under Health Flexible Spending Accounts (FSA) or Health Reimbursement Arrangements (HRA).

[2]Cannot exceed $5,000 ($2,500 if married, filing separately), per calendar year or earned income of employee or spouse, whichever is less.

isolved Benefit Services

Know Your Eligible and Ineligible Expenses

Eligible Expenses

Baby/Child to age 13
- Lactation consultant
- Lead-based paint removal*
- Special formula*
- Tuition: special school/teacher for disability or learning disability
- Well baby/well child care

Dental
- Dental x-rays
- Dentures and bridges
- Exams and teeth cleaning
- Extractions and fillings
- Oral surgery
- Orthodontia
- Periodontal services

Eyes
- Eye exams
- Eyeglasses and contact lenses
- Laser eye surgeries
- Prescription sunglasses
- Radial keratotomy

Hearing
- Hearing aids and batteries
- Hearing exams

Lab Exams/Tests
- Blood tests and Metabolism tests
- Body scans
- Cardiograms
- Laboratory fees
- X-rays

Medications
- Insulin
- OTC drugs
- Prescription drugs

Medical Equipment/Supplies
- Air purification equipment*
- Arches and other orthotic inserts
- Contraceptive devices
- Crutches, walkers, wheel chairs
- Exercise equipment*
- Hospital beds*
- Mattresses*
- Medic alert bracelet or necklace
- Nebulizers
- Orthopedic shoes*
- Oxygen
- Post-mastectomy clothing
- Prosthetics
- Syringes
- Wigs*

Obstetrics
- Doulas*
- Lamaze class
- OB/GYN exams
- OB/GYN prepaid maternity fees (reimbursable after date of birth)
- Pre- and post-natal treatments

Practitioners
- Allergist
- Chiropracter
- Christian Science Practitioner
- Dermatologist
- Homeopath
- Naturopath*
- Osteopath
- Physician
- Psychiatrist or Psychologist

Therapy
- Alcohol and Drug addiction
- Counseling (must be treating a medical condition)
- Exercise programs*
- Hypnosis*
- Massage*
- Occupational
- Physical
-Smoking cessation programs
- Speech
- Weight loss programs

Medical Procedures/Services
- Acupuncture
- Alcohol and drug/substance abuse (inpatient treatment and outpatient care)
- Ambulance
- Fertility enhancement and treatment
- Hair loss treatment*
- Hospital services
- Immunization
- In vitro fertilization
- Personal trainers*
- Physical examination (not employment-related)
- Reconstructive surgery (due to a congenital defect, accident or medical treatment)
- Service animals
- Sterilization/sterilization reversal
- Transplants (including organ donor)
- Transportation*

This list is not meant to be all-inclusive, as other expenses not specifically mentioned may also qualify. Also, expenses marked with an asterisk (*) are “potentially eligible expenses” that require a note of medical necessity from your health care provider to qualify for reimbursement. For additional information, check your Summary Plan Document or contact isolved Benefit Services.

Over-the-Counter (OTC) Medicines, purchased on or after January 1, 2020, were reinstated with the passage of the CARES Act (COVID-3 Stimulus Bill) for HSAs, FSAs and Archer MSAs (unless your plan excludes OTC items). OTC items can be purchased with funds from eligible accounts without needing a prescription. Additionally, the bill expanded OTC items to include menstrual care products.

Eligible Over-the-Counter Items

Note: Product categories are listed in bold face; common examples of products are listed in regular face.

The following is a high-level list of over-the-counter (OTC) items that are not medicine or drugs and are eligible for purchase with Health Care FSA dollars. You can use your benefits card for these items:

Antiseptics, wound cleaners
Alcohol, peroxide, Epsom salt

Baby electrolytes
Pedialyte, Enfalyte

Denture adhesives, repair and cleansers
PoliGrip, Benzodent, Efferdent

Diabetes testing and aids
Insulin, Ascencia, One Touch, Diabetic Tussin, insulin syringes, glucose products

Sunscreen (SPF 15 and over)

Diagnostic products
Thermometers, blood pressure monitors, cholesterol testing

Elastics/athletic treatments
ACE, Futuro, elastic bandages, braces, hot/cold therapy, orthopedic supports, rib belts

Eye care
Contact lens care

Family planning
Pregnancy and ovulation kits

First aid dressings and supplies
Band Aid, 3M Nexcare, non-sport tapes

Hearing aid/medical batteries

Incontinence products
Attends, Depend, GoodNites for juvenile incontinence

Feminine hygiene products
Sanitary pads, tampons, panty liners

Ineligible Expenses

Note: This list is not meant to be all-inclusive

The IRS does not allow the following expenses to be reimbursed the FSA, as they are not prescribed by a physician for a specific ailment.

Contact lens or eyeglass insurance

Cosmetic surgery/procedures

Electrolysis

Marriage or career counseling

Swimming lessons

Sunscreen (SPF less than 15 needs RX)

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Savings Snapshot

You can increase the money you take home each pay period by using a Flexible Benefits Plan. Here is an example of the tax savings an employee earning $2,200 a month can experience using this great benefit.

	Without 125 Plan	With 125 Plan
Monthly income before taxes	**$2,200.00**	**$2,200.00**
Pre-tax salary deductions		
Health FSA contribution	$.00	$60.00
Dependent Care FSA contribution	$.00	$260.00
Employee contribution to health plan	$.00	$50.00
Total	**$.00**	**$370.00**
Payroll taxes		
FICA (7.65%)	$168.30	$140.00
Federal income tax(12.16%)	$267.52	$222.53
State income tax (4%)	$88.00	$73.20
Total	**$.00**	**$435.73**
After tax expenses		
Health care expenses	$60.00	$.00
Dependent care expenses	$260.00	$.00
Employee contribution to health plan	$50.00	$.00
Total	**$370.00**	**$.00**
Spendable income	**$1,306.18**	**$1,394.27**

Employee's spendable income **increases**

$22.03 each week

$88.09 each month

$1,057.08 each year

Frequently Asked Questions

General Information

Why should I participate in the Flexible Benefits Plan?

There are some great advantages to using a Flexible Benefits Plan!

- Reduced taxes - the money contributed to an FSA is not subject to taxes (federal income and FICA taxes and most state and local income taxes).
- Increase your take-home pay - less taxes, more money in your pocket.
- The Benefits Card - pay for expenses at point of purchase.

A Flexible Benefits Plan applies to out-of-pocket expenses you cover with your spendable income, but allows you to pay for these expenses with income before you are taxed.

Another advantage to participating in the Plan is the opportunity it offers for you to budget for health care expenses by withholding a small amount from each paycheck. With proper planning, you won't be faced with having to come up with large amounts of money at one time. This is especially advantageous if you are scheduling a surgery, anticipating maternity expenses or if you do not have other coverage for dental and vision expenses. Even those with coverage for medical, dental and vision usually have deductibles, co-pays and other out-of-pocket expenses to cover.

Where do I call with questions about my Flexible Benefits Plan?

If you have questions about putting a Flexible Benefits Plan to work for you, how to sign up or how to determine your election amounts, etc., please call a Customer Service Representative at 800-300-9691.

Enrollment

How do I enroll?

To enroll in either or both the Health and Dependent Care FSA, you simply need to fill out the Enrollment Form or use your employer's benefits administration platform (if applicable) for you to make your election.

Do I have to keep the same election each year?

No. Each year, you will have to re-enroll before the beginning of the Plan Year. At that time, you will have the opportunity to evaluate the need to participate in the Plan as well as budget for all health care and/or dependent care expenses. You may decide to keep the same election, change your election or in some cases waive participation.

Do I have to elect both the Health and Dependent Care FSAs?

No. You may choose to participate in one or both depending on your individual needs.

Health FSAs

What is a Health Flexible Spending Account (FSA)?

You may set aside pre-tax dollars to cover eligible medical expenses that are not covered by any other type of insurance. The account helps you budget for planned expenses such as deductibles, co-payments and prescriptions. You may refer to the FSA Worksheet for a list of some eligible and ineligible expenses.

Are insurance premiums an eligible expense?

No, insurance premiums are not reimbursable from a Health FSA. However, you may pay your required premium contributions (for coverage under the employer's health plan) on a pre-tax basis outside of the Health FSA.

What are some examples of OTC drugs that are eligible for reimbursement from my Health FSA?

Antiseptics, diabetes testing aids, bandages and contact lens care. For a more inclusive list, please see the OTC expenses list available at infinisource.box.com/v/eligible-expenses.

If I terminate employment or retire, can I receive the remaining balance in my Health FSA?

No. However, you can continue to submit claims incurred prior to your termination date before the end of the run-out period (defined in your Summary Plan Description).

Example: Your plan has a 90-day run-out period following termination. Your termination date is September 13. Your physician sees you on September 12, but you do not receive the Explanation of Benefits from your insurance carrier until October 31. You can still submit this expense as it was incurred prior to your termination date, and prior to the end of the 90-day run-out period following your date of termination. Any expense incurred after September 13 is not eligible.

If I terminate employment or retire can I be reimbursed for expenses incurred after my termination date?

No. In order to be considered an eligible expense, the expense must be incurred prior to your termination date. However, you may be able to continue your Health FSA coverage under COBRA.

Dependent Care FSAs

What is a Dependent Care FSA?

You can use pre-tax dollars to cover eligible work-related dependent care expenses for qualified dependents, or if you are married, while you and your spouse work or your spouse attends school full-time.

Who is a qualified dependent under the Dependent Care FSA?

- Dependent under the age of 13
- Dependent or spouse of employee who is mentally or physically disabled and whom the employee claims as a dependent on his or her federal income tax return

Can an adult be a qualified dependent?
Yes, an adult may qualify as a dependent provided that the employee is providing more than half of that individual's support for the year and the dependent lives with the employee.

Do I have to use a day care facility?
No. You can be reimbursed for expenses of an individual providing care for your dependent in your home as long as the expenses are incurred for you and your spouse (if married), to work, look for work or attend school full-time.

Does my day care provider have to be licensed?
No. However, you are required to submit their Tax Identification Number or Social Security Number when filing your federal income tax return.

Does my day care provider have to be 18?
No, but the individual must claim the money as income on their tax return.

My child attends camp during the summer. Is this eligible?
Generally, no; however, if the camp is day camp and your dependent attends to allow you and your spouse (if married), to work, look for work or attend school full-time, then yes this would be an eligible expense. Overnight camps are specifically excluded.

When can I be reimbursed for dependent care expenses?
Expenses are eligible for reimbursement when they have been incurred, not when you are billed or when you pay for the services.

Example: Your day care provider requires you to pay for the month of September on September 1. You can be reimbursed as the services are incurred, not when you paid for the services. You can submit claims after each week, every two weeks or on October 1.

Changing Your Election

What if I discover that I elected too much for the Health and/or Dependent Care FSA, can I change my election?
Generally, your election is irrevocable unless you experience an IRS Change in Status. Your election change must be consistent with the Change in Status event:

- Change in legal marital status (marriage, death of spouse, divorce, legal separation, annulment)
- Change in number of tax dependents (birth, death of dependent, adoption or placement for adoption)
- Change in dependent's eligibility
- Change in employment status of employee, spouse or dependents
- Other changes that may permit an election change under the Dependent Care FSA are:
    - o Change of dependent care provider
    - o Change of rate charged by unrelated dependent care provider
    - o Child attaining age 13

Election changes must be consistent with the event. If you experience a Change in Status, please review your Summary Plan Description, as it will provide you with important information on the deadline for reporting this event.

If I elected too much in my Health FSA but not enough in my Dependent Care FSA, can I move money from one account to the other?

No, Health and Dependent Care FSA elections are separate. You cannot move contributions from one account to another. Also, it is very important to note that the elections you make are for the entire year. Your elections cannot be changed unless you experience an IRS Change in Status as noted above.

What happens if I don't use all the money elected in my FSA?

The IRS has issued guidance that allows a Health FSA to carry over up to $550 to the next plan year by plan design based on the plan sponsor's decision. A Health FSA cannot have both a carryover and a grace period of up to two months and 15 days. You also have a run-out period following the end of the plan year to submit expenses that were incurred during the plan year. It is important to estimate your expenses carefully before making your elections.

isolved Benefit Services will assist you in monitoring your Flexible Spending Accounts by providing you with a statement at the beginning of the fourth quarter of your plan year. You can minimize possible forfeitures by scheduling routine exams, purchasing glasses or contact lenses and scheduling dental appointments, etc., at the end of the plan year to use up your election amounts.

Submitting Claims for Reimbursement

How do I submit a claim for the Health or Dependent Care FSA?

You can file your claim online or via mobile app and upload your receipts.

You can complete an FSA Request for Reimbursement Form for each Health or Dependent Care FSA claim you file. This form can be found on your Online Portal. Remember to attach supporting documentation for the claim. This information can be faxed to 515-224-9256.

You may also submit your claim by mail: isolved Benefit Services, Inc.

1454 30th St STE 105
West Des Moines, IA 50266

May I submit expenses for my spouse and children for reimbursement through my Health FSA?

Yes, you may be reimbursed for expenses incurred for you, your spouse and any IRS dependents, regardless of where you are insured. It could be that you are not covered through your employer's health plan, but have coverage through your spouse's employer's plan. You may still submit your family out-of-pocket expenses to be reimbursed under the Health FSA.

What supporting documentation must I file with each Health FSA claim?

Each time you submit claims to your health insurance carrier, you will receive an Explanation of Benefits (EOB) detailing what the health plan will pay and what you must pay. For expenses that are partially covered under another insurance plan, you must attach a copy of both EOBs.

For expenses that are not submitted to another insurance plan, you must attach a copy of an itemized billing containing the following information:

- Name of patient
- Name and address of provider
- Description of service
- Date of service
- Amount of service

The documentation requirements are also listed on the FSA Request for Reimbursement Form to assist you in properly filing your claim. Following these guidelines will ensure you receive your reimbursement without unnecessary delays.

What supporting documentation must I file with each Dependent Care claim?

Complete the Dependent Care section of the Request for Reimbursement Form and have your day care provider sign and date. The receipt must include the following information:

- Name and address of provider
- From/through dates of service
- Amount of charge

How long after the end of the Plan year do I have to submit claims?

Claims must be submitted prior to the end of the run-out period for the Plan. The run-out period is defined in your Summary Plan Description.

Will I receive reimbursement for claims that are greater than the current balance of my Health FSA?

Yes, the annual amount is available to you from the beginning of the Plan year.

Will I receive reimbursement that is greater than the current balance of my Dependent Care FSA?

No, you will only receive reimbursement for the amount that has been contributed at the time you submit your claim.

Can I submit claims for dependent care expenses that are greater than the current balance of my Dependent Care FSA?

Yes, however, you will only receive reimbursement for the amount that you have contributed to your Dependent Care FSA. For example, if you contribute $150 each month to your Dependent Care FSA, then you will only receive $150 in reimbursement each month. The excess amount of expenses will be pended and automatically paid to you as contributions are posted to your account.

What happens if a claim exceeds the amount currently available in my Dependent Care FSA?

The claim will be processed and approved. The amount that is currently available will be disbursed and the remaining portion will be pended until you make another contribution.

How do I know that you received my claim and whether or not it was paid?

Generally, within two business days of submitting a claim, you can view your account to check on the status of the claim at www.isolvedbenefitservices.com/kabel. Simply choose Flexible Spending Account / Health Reimbursement under employee/participant and follow the on-screen instructions.

When can I expect to receive my reimbursement?

Claims are generally processed within two business days of receipt. Reimbursements are then processed and released according to the disbursement schedule and funding option of the employer. Generally, disbursement schedules are daily. This means that reimbursements are processed each day and include any claims that were processed the previous day. The release of your reimbursement depends upon the funding option chosen by the employer.

How do I know what my account balance is?

You can use one of the following methods to check your account balance:

- You can view your account at www.isolvedbenefitservices.com/wdm. Simply choose Flex/HRA/HSA participant to log in.
- You can view your balance on the mobile app.
- Your account balance will be displayed on the reimbursement check or direct deposit notification each time you submit a claim.
- You will receive a Balance Statement monthly during the Plan year in your employee portal. This statement provides a summary of your remaining balance in the Health FSA and/or the Dependent Care FSA as well as claims paid to date.

How do I know why my claim was denied?

You will receive an email or letter indicating the reason for the denial along with instructions for submitting the requested documentation.

Why may the amount of my reimbursement differ from the amount of my request?

There are reasons that you may see a different reimbursement amount. For example:

1. If the request was for more than the balance of your account.

Annual election	$1,000.00
Total amount disbursed to date	$700.00
Available balance	$300.00
Total amount of request	$500.00

2. If the request was for a dependent care claim, you may only be reimbursed for the total amount that you have contributed.

Annual election	$5,000.00
Total amount contributed	$3,000.00
Total amount of request	$4,250.00

You will only be reimbursed $3,000.00, as this is the amount that you have contributed to the account. The entire request of $4,250.00, will be processed and the remaining $1,250.00 will be disbursed as contributions are made.

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Dependent Care FSA FAQ

A Dependent Care FSA allows participants to use pre-tax dollars to cover eligible work-related dependent care expenses for qualified dependents, or if you are married, while you and your spouse work or your spouse attends school full-time.

Who is a qualified dependent under the Dependent Care FSA?

- Dependent under the age of 13
- Dependent or spouse of employee who is mentally or physically disabled and whom the employee claims as a dependent on their federal income tax return

Can an adult be a qualified dependent?

Yes, an adult may qualify as a dependent provided that the employee is providing more than half of that individual's support for the year and the dependent lives with the employee.

Do I have to use a day care facility?

No. You can be reimbursed for expenses of an individual providing care for your dependent in your home as long as the expenses are incurred for you and your spouse (if married), to work, look for work or attend school full-time.

Does my day care provider have to be licensed?

No. However, you are required to submit their Tax Identification Number or Social Security Number when filing your federal income tax return.

Does my day care provider have to be 18?

No, but the individual must claim the money as income on their tax return.

My child attends camp during the summer. Is this eligible?

Generally, no; however, if the camp is day camp and your dependent attends to allow you and your spouse (if married), to work, look for work or attend school full-time, then yes this would be an eligible expense. Overnight camps are specifically excluded.

When can I be reimbursed for dependent day care expenses?

Expenses are eligible for reimbursement when they have been incurred, not when you are billed or when you pay for the services.

Example: Your day care provider requires you to pay for the month of September on September 1. You can be reimbursed as the services are incurred, not when you paid for the services. You can submit claims after each week, every two weeks or on October 1.

Dependent Care FSA FAQ (continued)

What supporting documentation must I file with each Dependent Care claim?

Complete the Dependent Care section of the Request for Reimbursement Form and have your day care provider sign and date. The receipt must include the following information:

- Name and address of provider
- From/through dates of service
- Amount of charge

Can I submit claims for dependent care expenses that are greater than the current balance of my Dependent Care FSA?

Yes, however, you will only receive reimbursement for the amount that you have contributed to your Dependent Care FSA. For example, if you contribute $150 each month to your Dependent Care FSA, then you will only receive $150 in reimbursement each month. The excess amount of expenses will be pended and automatically paid to you as contributions are posted to your account.

What happens if a claim exceeds the amount currently available in my Dependent Care FSA?

The claim will be processed and approved. The amount that is currently available will be disbursed and the remaining portion will be pended until you make another contribution.

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The iFlexWDM App

You have your phone with you all the time. Why not use the iFlexWDM App to review your account information, take a photo of the receipt and submit the claim right away?

The iFlexWDM App connects you with the details

- Quickly check available balances 24/7
- Access account details
- View charts summarizing account(s)
- Click to call or email Customer Service

Provides additional time-saving options

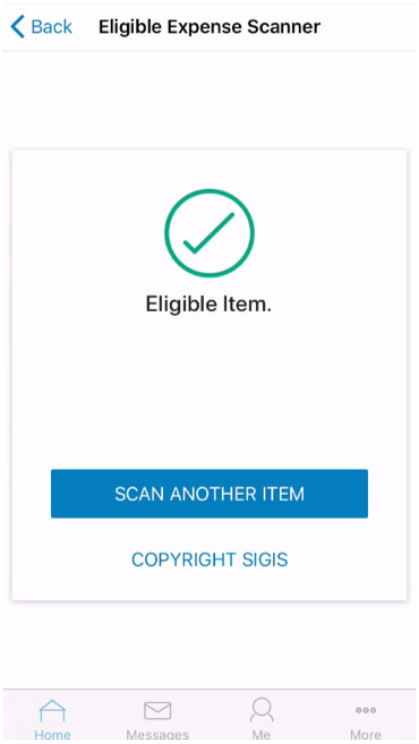
- View claims requiring receipts
- Submit medical FSA and HRA claims
- Take a picture of a receipt to submit for a claim
- View HSA transaction details
- Using Expense Tracker, enter medical expense information and support documentation to store for later use in paying claims via your health benefits website
- Report a lost or stolen debit card

The iFlexWDM App is easy, convenient and secure

Simply login to the app using your same health benefits website username and password (or follow alternative instructions if provided to you)

Follow these steps to download the iFlexWDM App

1. Visit the iTunes App Store or the Android Market and search for isolved Benefit Services WDM to download the app on your iPhone, iPad or Android.
2. Once installed, enter the Username and Password to log into your account at www.isolvedbenefitservices.com/wdm



Download on the App Store

GET IT ON Google Play

The iFlexWDM mobile app is available for free on Google Play and the App Store.

Transforming employee experience for a better today and a better tomorrow

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Flexible Spending Accounts.

Flexible. Simple. Hassle-free.

Are you hesitant to sign up for the company FSA? Now is the time to take advantage of savings and benefits that come along with an FSA.

To find resources, answers to questions, and lists of qualified expenses, visit the **isolved Benefit Services FSA Resource Center at:**

www.isolvedbenefitservices.com/wdm/resources

Higher Take-Home Pay

Higher take-home pay is one of the most appealing benefits of enrolling in an FSA. Learn more about an FSA and what is covered. You might be surprised to see how many items you're already buying are eligible under an FSA.

Auto Approval... Now that's something to flip over

Auto-approval (adjudication) on 93% of claims paid on the debit card. This means that you don't have to spend a lot of time submitting receipts, since the system will automatically approve payment for the items.

Easy FSA access any way you look at it

iFLEX WDM Mobile App allows access to your account balance. See how much you have to spend on qualified health or dependent care expenses at time of purchase. Also, submit claims for reimbursement and upload receipts using the camera on your mobile device.

Lighten your childcare expenses!

FSA Dependent Care can save you up to 30% on eligible child-care expenses, such as day-care, in-home care, nursery school, pre-school, and other qualifying care for dependents under age 13. A Dependent Care FSA also can cover adult relatives unable to provide their own care.

Transforming employee experience for a better today and a better tomorrow.

 • www.isolvedbenefitservices.com/wdm

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Flexible Spending Accounts

REAL SAVINGS. REAL SIMPLE.

Using a Flexible Spending Account (FSA) is a great way to stretch your benefit dollars. You use pre-tax dollars in your FSA to reimburse yourself for eligible out-of-pocket medical and dependent care expenses. That means you can enjoy tax savings with the convenience of a prepaid benefits card. And that makes real sense.

WHAT IS AN FSA?

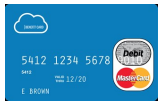
With an FSA, you elect to have your annual contribution (up to the annual limit set by the IRS) deducted from your paycheck each pay period in equal installments throughout the year. The amount of your pay that goes into an FSA will not count as taxable income, so you will have immediate tax savings. FSA dollars can be used during the plan year to pay for qualified expenses and services. Please check with your employer to see what plans are offered.

A Health FSA allows reimbursement of qualifying out-of-pocket medical expenses.

A Dependent Care FSA allows reimbursement of dependent care expenses, such as day care, incurred by eligible dependents.

A Limited Purpose Health FSA is compatible with a Health Savings Account (HSA). A limited FSA only allows reimbursement for preventive care, vision and dental expenses, keeping the employee eligible to contribute to an HSA.

With all FSA account types, you'll receive access to a secure, easy-to-use web portal where you can track your account balance, view your investment accounts and submit requests for reimbursements.



In addition, your plan might offer a convenient prepaid benefits card to make it easy to pay for eligible services and products. When you use the card, payments are automatically withdrawn from your account, so there are no out-of-pocket costs and you likely won't have to submit receipts to verify the purchase. Just swipe the card and go. It's that easy!

Throughout the year, you'll likely find yourself with expenses for yourself and your family that insurance won't cover. By taking advantage of a health care FSA, you can actually reduce your taxable income and reduce your out-of-pocket expenses when you use your FSA to pay for health care services and products you'd purchase anyway.

Is an FSA right for me? An FSA is a great way to pay for expenses with pre-tax dollars. A Health Care FSA could save you money if you or your dependents:

- Have out-of-pocket expenses like **co-pays, coinsurance, or deductibles** for health, prescription, dental or vision plans
- Have a **health condition that requires the purchase of prescription medications** on an ongoing basis
- Wear **glasses or contact lenses** or are planning **LASIK surgery**
- Need **orthodontia care, such as braces,** or have dental expenses not covered by your insurance

A Dependent Care FSA provides pre-tax reimbursement of out-of-pocket expenses related to dependent care. This benefit may make sense if you (and your spouse, if married) are working or in school, and:

- Your **dependent children under age 13 attend day care, after-school care** or **summer day camp**
- You **provide care for a person of any age who you claim as a dependent on your federal income tax return** and who is mentally or physically incapable of caring for himself or herself

An FSA is a great way to pay for expenses with pre-tax dollars.

- Enjoy significant tax savings with pre-tax contributions and tax-free distributions used for qualified plan expenses
- Quickly and easily access funds using the prepaid benefits card at point of sale, or request to have funds directly deposited to your bank account via online or mobile app
- Reduce filing hassles and paperwork by using your prepaid benefits card
- Enjoy secure access to accounts using a convenient Consumer Portal available 24/7/365
- Manage your FSA "on the go" with an easy-to-use mobile app
- File claims easily online (when required) and let the system determine approval based on eligibility and availability of funds
- Stay up to date on balances and action required with automated email alert and convenient portal and mobile home page messages
- Get one-click answers to benefits questions

With the convenience of a mobile device, you can see your available balance anywhere, anytime as well as file claims and upload receipts.

PLAN AHEAD Before you enroll, you must first decide how much you want to contribute to your account(s). You will want to spend some time estimating your anticipated eligible medical and dependent care expenses for the calendar year.

As of October 31, 2013 the US Treasury Department modified its Health Flexible Spending Account (FSA) Use-or-Lose rule to allow up to a $550 carryover of Health FSA funds. The carryover option is based solely on your employer's plan design. Not every company allows a carryover. Some employer plans may establish a lower maximum limit than $550 , but it must be uniformly applied to all eligible participants. The carryover is applicable only to Health FSAs (not to Dependent Care FSAs). Any unused amount above the carryover limit is subject to forfeiture and cannot be cashed out or transferred to other taxable or nontaxable benefits (e.g., HSAs).

For questions, contact us at: flexteamkb@isolvedhcm.com or 515-224-9400

isolved Benefit Services

www.isolvedbenefitservices.com/wdm

Required Notices

County Employee Benefit Consortium of Ohio
CEBCO
Health & Wellness

Dear CEBCO Plan Participant,

The enclosed notices are provided to you periodically as a part of the service you receive from your CEBCO health coverage.

These notices contain important information about your rights as a plan participant.

No action is necessary on your part.

You may want to retain these with other important insurance papers for future reference.

Respectfully,

The CEBCO Team

Michael Kindell, Managing Director

Melissa Bodey, Senior Benefit Specialist
Wendy Dillingham, Senior Benefit Specialist
Justin Grant, Benefit Specialist

Debi Burnette, Enrollment and Billing Specialist

Hannah McKee, Wellness Coordinator
Laurie O'Brien, Wellness Coordinator

County Employee Benefits Consortium of Ohio 209 E. State Street, Columbus, Ohio 43215

HIPAA NOTICE OF PRIVACY PRACTICES

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

Health Information Privacy

This Notice is required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and is intended to describe how the CEBCO Employees Benefit Plan (which includes underlying health plan coverages for medical, dental, prescription drug, and vision), the Employee Assistance Program, and health coverages provided by health insurance issuers or health maintenance organizations that provide health information to or on behalf of the health plans (collectively, "Health Plans"), to the extent applicable to you, will protect your health information. For purposes of HIPAA, "health information" means information that identifies you and either relates to your physical or mental health condition, or relates to the payment of your health care expenses. This individually identifiable health information is known as "protected health information" ("PHI"). Your PHI will not be used or disclosed without a written authorization from you, except as described in this Notice or as otherwise permitted by federal or state health information privacy laws.

Health Plan Privacy Obligations

The Health Plans are required by law to:

- Ensure that health information that identifies you is kept private;
- Provide you with Notice of their legal duties and privacy practices with respect to health information about you;
- Follow the terms of the Notice that are in effect; and
- Notify you in the event of a breach involving unsecured PHI,

How the Health Plans May Use and Disclose Your Health Information

The Health Plans may use health information or disclose it to others for a number of different reasons. The following are the different ways that the Health Plans may use and disclose your PHI without your authorization:

• **For Treatment.** The Health Plans may disclose your PHI to a health care provider who provides, coordinates or manages health care treatment on your behalf. For example, if you are unable to provide your medical history as a result of an accident, the Health Plans may advise an emergency room physician about the different medications that you may have been prescribed.

• **For Payment.** The Health Plans may use and disclose your PHI so claims for health care treatment, services, and supplies that you receive from health care providers may be paid according to the Health Plans' terms. The Health Plans may also use your PHI for billing, reviews of health care services received, and subrogation. For example, the Health Plans may tell a doctor or hospital whether you are eligible for coverage or what percentage of the bill will be paid by the Health Plans.

• **For Health Care Operations.** The Health Plans may use and disclose your PHI to enable them to operate more efficiently or to make certain that all of their participants receive the appropriate health benefits. For example, the Health Plans may use your PHI for case management, to refer individuals to disease management programs, for underwriting, premium rating, activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, to arrange for medical reviews, or to perform population-based studies designed to reduce health care costs. However, the Health Plans will not use or disclose PHI that is genetic information for underwriting purposes. In addition, the Health Plans may use or disclose your PHI to conduct compliance reviews, audits, legal reviews, actuarial studies, and/or for fraud and abuse detection. The Health Plans may also combine health information about participants and disclose it to CEBCO and its affiliated companies (collectively, "CEBCO") in a non-identifiable, summary fashion so that CEBCO can decide, for example, what types of coverage the Health Plans should provide. The Health Plans may also remove information that identifies you from health information that is disclosed to CEBCO so that the health information that is used by CEBCO does not identify the specific Health Plan participants.

- **Other Covered Entities**. The Health Plans may use or disclose your health information to assist health care providers in connection with their treatment and payment activities, or to assist other covered entities with certain health care operations. For example, the Health Plans may disclose or share your information with other health care programs or insurance carriers (such as Medicare) in order to coordinate benefits if you or your family members have other health insurance or coverage.

• **To The Plan Sponsor.** The Health Plans are sponsored by CEBCO. The Health Plans may disclose your PHI to designated personnel at CEBCO so that they can carry out related administrative functions, including the uses and disclosures described in this Notice. Such disclosures will be made only to the individuals authorized to receive such information under the Health Plans. These individuals will protect the privacy of your health information and ensure that it is used only as described in this Notice or as permitted by law. Unless authorized by you in writing, your health information:

(1) May not be disclosed by the Health Plans to any other employee or department of CEBCO, and

(2) Will not be used by CEBCO for any employment-related actions or decisions, or in connection with any other employee benefit plans sponsored by CEBCO.

• **To a Business Associate.** Certain services are provided to the Health Plans by third-party administrators known as "business associates." For example, the Health Plans may place information about your health care treatment into an electronic claims processing system maintained by a business associate so that your claim may be paid. In so doing, the Health Plans will disclose your PHI to their business associates so that the business associates can perform their claims payment functions. However, the Health Plans will require their business associates, through written agreements, to appropriately safeguard your health information.

• **For Treatment Alternatives.** The Health Plans may use and disclose your PHI to tell you about possible treatment options or health care alternatives that may be of interest to you.

• **For Health-Related Benefits and Services.** The Health Plans may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.

• **To Individuals Involved in Your Care or Payment of Your Care.** The Health Plans may disclose PHI to a close friend or family member involved in or who helps pay for your health care. The Health Plans may also advise a family member or close friend about your condition, your location (for example, that you are in the hospital), or death, unless other laws would prohibit such disclosures. In these situations, when you are present and not incapacitated, the Health Plans will either (1) obtain your agreement; (2) provide you with an opportunity to disagree to the use or disclosure; or (3) using reasonable judgment, infer from the circumstances that you do not object to the disclosure. If you are not present, or you cannot agree or disagree to the use or disclosure due to incapacity or emergency circumstances, the Health Plans may use professional judgment to determine that the disclosure is in your best interests and disclose PHI relevant to such person's involvement in your care, payment related to your health care, or notification purposes. If you are deceased, the Health Plans may disclose PHI to such individuals involved in your care or payment for your health care prior to your death the PHI that is relevant the individual's involvement, unless you have previously instructed the Plan otherwise.

• **As Required by Law.** The Health Plans will disclose your PHI when required to do so by federal, state, or local law, including those laws that require the reporting of certain types of wounds, illnesses or physical injuries.

Special Use and Disclosure Situations

The Health Plans may also use or disclose your PHI without your authorization under the following circumstances:

• **Lawsuits and Disputes.** If you become involved in a lawsuit or other legal action, the Health Plans may disclose your PHI in response to a court or administrative order, subpoena, warrant, discovery request, or other forms of lawful due process.

• **Law Enforcement.** The Health Plans may release your PHI if asked to do so by a law enforcement official, for example, to report child abuse, to identify or locate a suspect, material witness, missing person or to report a crime, the crime's location or victims, or the identity, description, or location of the person who committed the crime.

• **Workers' Compensation.** The Health Plans may disclose your PHI to the extent authorized by and to the extent necessary to comply with workers' compensation laws and other similar programs.

• **Military and Veterans.** If you are or become a member of the U.S. armed forces, the Health Plans may release medical information about you as deemed necessary by military command authorities.

• **To Avert Serious Threat to Health or Safety.** The Health Plans may use and disclose your PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person.

• **Public Health Risks.** The Health Plans may disclose health information about you for public health activities. These activities include preventing or controlling disease, injury or disability; reporting births and deaths; reporting child abuse or neglect; reporting reactions to medications or problems with medical products, or notifying people of recalls of products they have been using.

• **Health Oversight Activities.** The Health Plans may disclose your PHI to a health oversight agency for audits, investigations, inspections, and licensure necessary for the government to monitor the health care system and government programs.

• **Research.** Under certain limited circumstances, the Health Plans may use and disclose your PHI for medical research purposes.

• **National Security, Intelligence Activities, and Protective Services.** The Health Plans may release your PHI to authorized federal officials: (1) for intelligence, counterintelligence, and other national security activities authorized by law or (2) to enable them to provide protection to the members of the U.S. government or foreign heads of state, or to conduct special investigations.

• **Organ and Tissue Donation.** If you are an organ donor, the Health Plans may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation, or to an organ donation bank to facilitate organ or tissue donation and transplantation.

• **Coroners, Medical Examiners, and Funeral Directors.** The Health Plans may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. The Health Plans may also release your PHI to a funeral director, as necessary, to carry out his/her responsibilities.

- Abuse, Neglect, or Domestic Violence. The Health Plans may, under certain circumstances, disclose PHI about individuals who are reasonably believed to be a victim of abuse, neglect, or domestic violence to a government authority, including a social service or protective services agency, authorized by law to receive such reports.

- **Disclosures to You**. The Health Plans are required to disclose to you or your personal representative most of your health information. A "personal representative" is an individual designated by your or by applicable law to act on your behalf in health care matters. The Health Plans may elect not to treat the individual as your personal representative if they have a reasonable belief that: you have been, or may be, subject to abuse or neglect by the individual; treating the individual as a personal representative could endanger you; or the Health Plans determine, in the exercise of their professional judgment, that it is not in your best interests to treat the individual as a personal representative.

Your Rights Regarding Your Health Information

You have the following rights regarding the health information that the Health Plans maintain about you:

• **Right to Inspect and Copy Your Personal Health Information.** You have the right to inspect and copy your PHI that is maintained in a "designated record set" as long as the Health Plans maintain your PHI. A "designated record set" includes medical information about eligibility, enrollment, claim and appeal records, and medical and billing records maintained by the Health Plans, but does not include psychotherapy notes, information intended for use in a civil, criminal or administrative proceeding, or information that is otherwise prohibited by law.

To inspect and copy health information maintained by the Health Plans, submit your request in writing to CEBCO, 209 E. State Street, Columbus, OH 43215. If your medical information is maintained in an electronic health record, you also have the right to request that an electronic copy of your record be sent to you or to another individual or entity.

The Health Plans may charge a fee for the cost of copying and/or mailing your request, or the labor costs associated with transmitting an electronic health record. The Health Plans must act upon your request for access no later than 30 days after receipt (60 days if the information is maintained off-site). A single, 30-day extension is allowed if the Health Plans are unable to comply by the initial deadline. In limited circumstances, the Health Plans may deny your request to inspect and copy your PHI. Generally, if you are denied access to your health information, you will be informed as to the reasons for the denial, and of your right to request a review of the denial.

• **Right to Amend Your Personal Health Information.** If you feel that the health information the Health Plans have about you is incorrect or incomplete, you may ask the Health Plans to amend it. You have the right to request an amendment of your PHI that the Health Plans maintain in a designated record set, for as long as your PHI is maintained in a Designated Record Set.

To request an amendment, send a detailed request in writing to CEBCO, 209 E. State Street, Columbus, OH 43215. You must provide the reason(s) to support your request. The Health Plans may deny your request if you ask the Health Plans to amend health information that was:

(1) Accurate and complete;

(2) Not created by the Health Plans;

(3) Not part of the health information maintained by or for the Health Plans; or

(4) Not information that you would be permitted to inspect and copy. The Health Plans have 60 days after the request is received to act on the request. A single, 30-day extension is allowed if the Health Plans cannot comply by the initial deadline. If the request is denied, in whole or in part, the Health Plans will provide you with a written denial that explains the basis for the denial. You may then submit a written statement disagreeing with the denial and, if permitted under HIPAA, have that statement included with any future disclosures of your PHI.

• **Right to An Accounting of Disclosures.** You have the right to request an "accounting of disclosures" of your PHI. This is a list of disclosures of your PHI that the Health Plans have made to others for the six (6) year period prior to the request, except for those disclosures necessary to carry out treatment, payment, or health care operations, disclosures previously made to you, disclosures where authorization was provided, disclosures to family members or friends involved in your care (where disclosure is permitted without authorization), disclosures for national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances, disclosures as part of a limited data set (health information that excludes certain identifying information), disclosures that occurred prior to April 14, 2003 (the HIPAA compliance date), or in certain other situations described under HIPAA.

To request an accounting of disclosures, you may submit your request in writing to CEBCO, 209 E. State Street, Columbus, OH 43215. Your request must state a time period, which may not be longer than six (6) years prior to the date the accounting was requested. If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the Health Plans provide you with a written statement of the reasons for the delay and the date by when the accounting will be provided. If you request more than one accounting within a 12-month period, the Health Plans will charge a reasonable, cost-based fee for each subsequent accounting.

• **Right to Request Restrictions.** You have the right to request a restriction on the health information that the Health Plans use or disclose about you for treatment, payment, or health care operations. The Health Plans are not required to agree to a requested restriction, except in those situations where the requested restriction relates to the disclosure to the Health Plans for purposes of carrying out payment or health care operations (and not for treatment), and the PHI pertains solely to a health care item or service that was paid for out of pocket in full. You also have the right to request that the Health Plans limit the individuals (for example, family members) to whom the Health Plans may disclose your health information. For example, you may request that the Health Plans not use or disclose information about a surgical procedure that you have had. While the Health Plans will consider your request, they are not required to agree to it except as noted above. If the Health Plans agree to the restriction, they will comply with your request until such time as the Health Plans provide written notice to you of their intent to no longer agree to such restriction, or unless such disclosure is required by law.

To request a restriction or limitation, make your request in writing to CEBCO, 209 E. State Street, Columbus, OH 43215. In your request, you must state:

(1) What information you want to limit;

(2) Whether you want to limit the health plans' use, disclosure, or both; and

(3) To whom you want the limit(s) to apply. Note: the health plans are not required to agree to your request except as noted above.

• **Right to Request Confidential Communications.** You have the right to request that the Health Plans communicate with you about health matters using alternative means or at alternative locations. For example, you may ask that the Health Plans send your explanation of benefits ("EOB") forms about your benefit claims to a specified address. To request confidential communications, make your request in writing to CEBCO, 209 E. State Street, Columbus, OH 43215. The Health Plans will make every attempt to accommodate all reasonable requests. Your request must specify how or where you want to be contacted.

• **State Privacy Rights.** You may have additional privacy rights under state laws, including rights in connection with mental health and psychotherapy reports, pregnancy, HIV/AIDS-related illnesses, and the health treatment of minors.

• **Right to a Paper Copy of this Notice.** You have the right to a paper copy of this Notice upon request. This right applies even if you have previously agreed to accept this Notice electronically. You may write to CEBCO, 209 E. State Street, Columbus, OH 43215 to request a written copy of this Notice at any time.

Changes to this Privacy Notice

The Health Plans must abide by the terms of the Privacy Notice currently in effect. This Notice originally took effect on April 14, 2003, and was updated effective January 1, 2011 and September 23, 2013. However, the Health Plans reserve the right to change this Notice at any time, and from time to time, and to make the revised or changed Notice effective for health information that the Health Plans already have about you, as well as any information that the Health Plans may receive in the future. The revised Notice will either be provided to you in the same or similar manner as this Notice, or electronically if you have consented to receive the Notice electronically.

Complaints

If you believe that your health information privacy rights as described under this Notice have been violated, you may file a written complaint with the Health Plans by contacting the person listed at the address under "Contact Information". You may also file a written complaint directly with the Secretary of the U.S. Department of Health and Human Services, at either the Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Hubert H. Humphrey Building, Washington, D.C. 20201, or the appropriate Regional Office of the Office for Civil Rights. The complaint should generally be filed within 180 days of when the act or omission complained of occurred.
Note: You will not be penalized or retaliated against for filing a complaint.

Other Uses and Disclosures of Health Information

Other uses and disclosures of health information not covered by this Notice or by the laws that apply to the Health Plans will be made only with your written authorization. Your written authorization is also required for:

- Most uses or disclosures of psychotherapy notes (where appropriate);
- Uses or disclosures of your PHI for marketing purposes. Marketing does not include communications, involving no financial remuneration, for certain treatment or health care operations purposes, such as communications about entities that participate in a health plan network, health plan enhancements or replacements, case management or care coordination, or contacting individuals about treatment alternatives; and
- Disclosures of PHI that are considered a sale of PHI under the Privacy Rule.

If you authorize the Health Plans to use or disclose your PHI, you may revoke the authorization, in writing, at any time. If you revoke your authorization, the Health Plans will no longer use or disclose your PHI for the reasons covered by your written authorization; however, the Health Plans will not reverse any uses or disclosures already made in reliance on your prior authorization.

Contact Information

To receive more information about the Health Plans' privacy practices or your rights, or if you have any questions about this Notice, please contact the Health Plans at the following address:

Health Plan Name(s): CEBCO Employees Benefit Plan,
209 E. State Street
Columbus, OH 43215

Effective Date of this Notice: January 1, 2011, as amended effective September, 2014.

Important Notice from *CEBCO* 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 *CEBCO* 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. ***CEBCO* has determined that the prescription drug coverage offered by the *CEBCO* 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 ***CEBCO*** coverage ***will not*** be affected. Your current coverage pays for other health expenses in addition to prescription drug. If you enroll in a Medicare prescription drug plan, you and your eligible dependents ***will*** still be eligible to receive all of your current health and prescription drug benefits. ***For further information on how your coverage will be affected, please contact your benefit office.***

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

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

You should also know that if you drop or lose your current coverage with ***CEBCO*** 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 information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through ***CEBCO*** 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: *08/01/2023*
Name of Entity/Sender: *CEBCO Health and Wellness Program*
Address: *209 E. State Street Columbus, OH 43215*
Phone Number: 888-757-1904

County Employee Benefit Consortium of Ohio

CEBCO

Health & Wellness

WHCRA Notice

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 consulataion 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 deductible and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, contact Anthem Customer Service at **1-855-603-7982**. (You will be asked for your Anthem ID number.)

2023-24 NOTICE REGARDING WELLNESS PROGRAM

The wellness program provided by CEBCO (County Employee Benefit Consortium of Ohio) in partnership with our contracted wellness vendor, is a voluntary program available to all employees and spouses enrolled in the CEBCO medical plan. The program is administered according to federal rules permitting plan-sponsored wellness programs that seek to maintain/improve personal health and prevent disease. The program is compliant with the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act (HIPAA), as applicable, among others. If you and/or your spouse choose to participate in the wellness program, you/your spouse will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You may also be asked to complete your annual wellness preventive exam with your primary care provider, recommended vaccinations, and a number of screenings and/or lab tests as applicable to you based on your age, gender and risk level, such as a lipids test, A1C test, or a prostate, skin cancer, colorectal cancer, or breast cancer screening.

Should you/your spouse choose to participate, the information from your HRA will be used to provide you with information to help you understand your current health status and any potential risks. It may also be used to offer you additional services available through the wellness program, such as health coaching. You are highly encouraged to share your screening results or any health concerns with your primary care physician.

PROTECTIONS FROM DISCLOSURE OF MEDICAL INFORMATION

CEBCO's contracted wellness vendor is required by law to maintain the privacy and security of your personal health information. Although CEBCO and your employer may use aggregate information collected to design a program based on identified health risks in the population, your personal information is never disclosed either publicly, to your plan sponsor (CEBCO), or to your employer. Any medical information 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 when required by law. 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 personal health information are nurses and/or health coaches staffed with CEBCO's wellness vendor in order to provide you with services under the wellness program. 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, you will be notified 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.

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 January 31, 2022. Contact your State for more information on eligibility –

ALABAMA-Medicaid	CALIFORNIA-Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA-Medicaid	**COLORADO-Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS-Medicaid	**FLORIDA-Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA-Medicaid	MAINE-Medicaid
A HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711
INDIANA-Medicaid	**MASSACHUSETTS-Medicaid and CHIP**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840
IOWA-Medicaid and CHIP (Hawki)	**MINNESOTA-Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
KANSAS-Medicaid	**MISSOURI-Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KENTUCKY-Medicaid	**MONTANA-Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
LOUISIANA-Medicaid	**NEBRASKA-Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA-Medicaid	SOUTH CAROLINA-Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
NEW HAMPSHIRE-Medicaid	**SOUTH DAKOTA-Medicaid**
Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW JERSEY-Medicaid and CHIP	**TEXAS-Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NEW YORK-Medicaid	**UTAH-Medicaid and CHIP**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH CAROLINA-Medicaid	**VERMONT-Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
NORTH DAKOTA-Medicaid	**VIRGINIA-Medicaid and CHIP**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OKLAHOMA-Medicaid and CHIP	**WASHINGTON-Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
OREGON-Medicaid	**WEST VIRGINIA-Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
PENNSYLVANIA-Medicaid	**WISCONSIN-Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
RHODE ISLAND-Medicaid and CHIP	**WYOMING-Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2022, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2023)

SPECIAL ENROLLMENT NOTICE

This notice is being provided to make certain that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive health insurance coverage at this time.

Loss of Other Coverage

If you are declining coverage 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).

Example: You waived coverage under this plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this health plan.

Marriage, Birth, or Adoption

If you have a new dependent as a result of a 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, or placement for adoption.

Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this group health plan. However, you must apply within 30 days from the date of your marriage.

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this health plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this group health plan if you apply within 60 days of the date of their loss of CHIP coverage.

For More Information or Assistance

To request special enrollment or obtain more information, please contact:

Name	Christine Carrigan
Address	514 S. Main St.
City, State	Findlay, OH 45840
Telephone	419-424-7049

Note: If you or your dependents enroll during a **special enrollment period**, as described above, you will not be considered a late enrollee. Therefore, your group health plan may not impose a preexisting condition exclusion period of more than 12 months. Any preexisting condition exclusion period will be reduced by the amount of your prior creditable health coverage. **Effective for plan years beginning on or after Jan. 1, 2014, health plans may not impose pre-existing condition exclusions on any enrollees.**

04/14

Newborns' and Mothers' Protection Act Disclosure

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).

Genetic Information Nondiscrimination Act (GINA)

GINA, along with the Health Insurance Portability and Accountability Act (HIPAA), prohibits discrimination in group health plan coverage based on genetic information. GINA also prohibits a health plan from requesting or requiring you or your dependents to take a genetic test, requesting or requiring genetic information (including family medical history) or imposing a pre-existing condition exclusion provision based solely on genetic information.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Beginning in 2014, there is 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.

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.

You can get coverage through the Marketplace for 2024 if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP). The Marketplace's next open enrollment period begins on Nov. 1, 2023, for coverage starting as early as Jan. 1, 2024.

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 8.39 percent 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 . (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.)

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 contact Christine Carrigan 419-424-7049.

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, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.