



Employee Benefits Enrollment Guide



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:

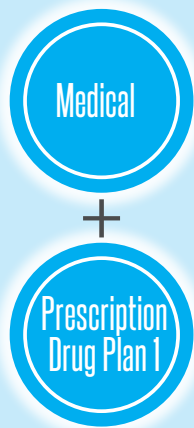
Benefits Account Executive: Lori Huth, 419-436-7632, lhuth@firstinsurancegrp.com

Customer Service Team: 1-833-936-1179 BenefitService@firstinsurancegrp.com

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

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

firstinsurancegrp.com



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



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



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



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



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



Employee Benefits

Customer Service Team



Our Customer Service Team's available to assist you and your employees with questions regarding your benefit offerings.

- **Eligibility**
- **Covered benefits**
- **Claims inquiries**
- **Provider network status**
- **Identification card replacements**

We love to help! Please contact our Customer Service Team today.

 1-833-936-1179

 BenefitService@FirstInsuranceGrp.com

 FirstInsuranceGrp.com

Insurance Products Are:

Not Insured by FDIC or Any Other Government Agency ▪ Not Bank Guaranteed
Not Bank Deposits or Obligations ▪ May Lose Value

Insurance products are provided through Premier Bank's affiliate,
First Insurance Group, a licensed insurance agency providing insurance services.

 **first insurance**
GROUP

A PREMIER FINANCIAL COMPANY



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
	\$60.32	\$159.62

EMPLOYEE PER PAY DEDUCTIONS (24 PAYS) – ANTHEM MEDICAL HSA 3 AND DELTA DENTAL

	Employee Only	Employee & Family
	\$13.11	\$34.71

EMPLOYEE PER PAY DEDUCTIONS (24 PAYS) – VSP VISION

	Employee Only	Employee & Spouse Employee & 1 Child	Employee & Children Employee & Family
	\$1.21	\$3.36	\$8.91

Required Forms and Applications





2023 Plan Coverage Election Form

Employee Information:		Department	
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 and add dependent information below.			Medical/Prescription/ Dental PPO 1F
		Employee Contribution Per Pay (24 Pays)	Pre-Tax
Employee Only	\$60.32	<input type="checkbox"/>	<input type="checkbox"/>
Family	\$159.62	<input type="checkbox"/>	
MEDICAL/PRESCRIPTION - Anthem/CEBCO HSA E2 and DENTAL - Delta (Eligibility - 30+ hours) *Please check the appropriate box and add dependent information below.			Medical/Prescription/ Dental HSA E2
		Employee Contribution Per Pay (24 Pays)	Pre-Tax
Employee Only	\$13.11	<input type="checkbox"/>	<input type="checkbox"/>
Family	\$34.71	<input type="checkbox"/>	
Waiving Coverage		\$0	<input type="checkbox"/>
Dependents to be Covered on Medical Plan:			
Name:	DOB:	SS#:	Relationship:
Name:	DOB:	SS#:	Relationship:
Name:	DOB:	SS#:	Relationship:
Name:	DOB:	SS#:	Relationship:
Vision - VSP (Eligibility - 30+ hours) *Please check the appropriate box and add dependent information below.			Vision
		Employee Contribution Per Pay (24 Pays)	Pre-Tax
Employee Only or	\$1.21	<input type="checkbox"/>	<input type="checkbox"/>
Employee & Spouse or Employee & 1 Child	\$3.36	<input type="checkbox"/>	
Employee & Children or Family	\$8.91	<input type="checkbox"/>	
Waiving Coverage		\$0	<input type="checkbox"/>
Dependents to be Covered on Vision Plan: Initial if same as medical _____			
Name:	DOB:	SS#:	Relationship:
Name:	DOB:	SS#:	Relationship:
Name:	DOB:	SS#:	Relationship:
Name:	DOB:	SS#:	Relationship:
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 \$3,850 for single coverage and \$7,750 for family coverage for the 2023 calendar year. The catch-up provision allows participants age 55 and older to deposit an additional \$1,000 for 2023.			\$ _____ Pre-Tax Deduction

Employer Paid Life Insurance - Anthem (Eligibility - 30+ Hours)				Employer Paid Life Insurance	
*You must complete an application to enroll in this coverage at no cost to you.					
LIFE BENEFICIARY DESIGNATION					
Primary Beneficiary					
Last Name:	First Name:	SS#:	Relationship	%	
Last Name:	First Name:	SS#:	Relationship	%	
Last Name:	First Name:	SS#:	Relationship	%	
Last Name:	First Name:	SS#:	Relationship	%	
Contingent Beneficiary					
Last Name:	First Name:	SS#:	Relationship	%	
Last Name:	First Name:	SS#:	Relationship	%	
Last Name:	First Name:	SS#:	Relationship	%	
Last Name:	First Name:	SS#:	Relationship	%	

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: _____

Cafeteria/Flex Plan Enrollment Form

Company Name (Employer)

Employee Information

First Name	Last Name	Middle Initial
SSN	Date of Birth	Email <i>(required)</i>
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 claiming 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





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
ComPysch	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


CEBCO: Hancock County PPO Plan 1F Rx 1F



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, <https://eoc.anthem.com/eocdps/aso>. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call (833) 639-1634 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$500/person or \$1,000/family for In- Network Providers . \$1,000/person or \$2,000/family for Non- Network Providers .	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible ?	Yes. Primary Care. Specialist Visit . Preventive Care . Certain Prescription Drugs . Vision. For more information see below.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	\$3,000/person or \$6,000/family for In- Network Providers . \$6,000/person or \$12,000/family for Non- Network Providers . This plan has a separate Out of Pocket Maximum of \$2,500/single or \$5,000/family for In- Network Providers for Prescription Drugs .	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Prescription Drugs , Premiums , balance-billing charges, health care this plan doesn't cover, and Non- Network Transplants.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if	Yes, Blue Access. See	This plan uses a provider network . You will pay less if you use a provider in the plan's

you use a network provider ?	www.anthem.com or call (833) 639-1634 for a list of network providers . Costs may vary by site of service and how the provider bills.	network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral .

 All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20/visit deductible does not apply	40% coinsurance	Virtual visits (Telehealth) benefits available.
	Specialist visit	\$40/visit deductible does not apply	40% coinsurance	Virtual visits (Telehealth) benefits available.
	Preventive care / screening /immunization	No charge	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	40% coinsurance	-----none-----
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	-----none-----
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://www.anthem.com/pharmacyinformation/	Tier 1 - Typically Generic	\$10/prescription, deductible does not apply (retail) and \$20/prescription, deductible does not apply (home delivery)	Not covered (retail) and Not covered (home delivery)	For more information, refer to "National Drug List" at http://www.anthem.com/pharmacyinformation/ *See Prescription Drug section
	Tier 2 - Typically Preferred Brand & Non-Preferred Generic Drugs	\$20/prescription, deductible does not apply (retail) and \$40/prescription, deductible does not apply (home delivery)	Not covered (retail) and Not covered (home delivery)	
	Tier 3 - Typically Non-Preferred Brand and Generic drugs	\$40/prescription, deductible does not apply (retail) and \$80/prescription, deductible does not apply (home delivery)	Not covered (retail) and Not covered (home delivery)	

* For more information about limitations and exceptions, see **plan** or policy document at <https://eoc.anthem.com/eocdps/aso>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Tier 4 - Typically Preferred Specialty (brand and generic)	\$40/prescription, deductible does not apply (retail and home delivery)	Not covered (retail) and Not covered (home delivery)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	-----none-----
	Physician/surgeon fees	20% coinsurance	40% coinsurance	-----none-----
If you need immediate medical attention	Emergency room care	\$300/visit then 0% coinsurance deductible does not apply	Covered as In- Network	Copay waived if admitted.
	Emergency medical transportation	20% coinsurance	Covered as In- Network	-----none-----
	Urgent care	\$75/visit deductible does not apply	40% coinsurance	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	90 days/benefit period for Inpatient physical medicine, rehabilitation including day rehabilitation programs and skilled nursing services combined.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit \$20/visit deductible does not apply Other Outpatient 20% coinsurance	Office Visit 40% coinsurance Other Outpatient 40% coinsurance	Office Visit Virtual visits (Telehealth) benefits available. Other Outpatient -----none-----
	Inpatient services	20% coinsurance	40% coinsurance	-----none-----
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	100 visits/benefit period including private duty nursing
	Rehabilitation services	\$40/visit deductible does not apply	40% coinsurance	*See Therapy Services section.

* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/aso>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Habilitation services	\$40/visit deductible does not apply	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	90 days/benefit period for Inpatient physical medicine, rehabilitation including day rehabilitation programs and skilled nursing services combined.
	Durable medical equipment	20% coinsurance	40% coinsurance	*See Durable Medical Equipment Section
	Hospice services	20% coinsurance	40% coinsurance	-----none-----
If your child needs dental or eye care	Children's eye exam	No charge	40% coinsurance	*See Vision Services section
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	-----none-----

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- | | | |
|---|--|--|
| <ul style="list-style-type: none"> • Acupuncture • Dental care (Pediatric) • Hearing aids • Routine foot care | <ul style="list-style-type: none"> • Cosmetic surgery • Dental Check-up • Infertility treatment • Weight loss programs | <ul style="list-style-type: none"> • Dental care (Adult) • Glasses for a child • Long-term care |
|---|--|--|

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- | | | |
|--|--|--|
| <ul style="list-style-type: none"> • Bariatric surgery for In-Network Providers • Private-duty nursing only covered in the home 82 visits/benefit period. 164 visits/lifetime. 100 visits/benefit period including home health care. | <ul style="list-style-type: none"> • Chiropractic care 12 visits/benefit period • Routine eye care (Adult) | <ul style="list-style-type: none"> • Most coverage provided outside the United States. See www.bcbsglobalcore.com |
|--|--|--|

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Ohio Department of Insurance, 50 W. Town Street, Third Floor - Suite 300, Columbus, Ohio 43215, (800) 686-1526, (614) 644-2673, Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, www.cciio.cms.gov, or contact Anthem at the number on the back of your ID card. Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/aso>.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact:

ATTN: Grievances and Appeals, P.O. Box 105568, Atlanta GA 30348-5568

Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, www.cciio.cms.gov

Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/aso>.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)		Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The plan's overall deductible	\$500	■ The plan's overall deductible	\$500	■ The plan's overall deductible	\$500
■ Specialist copayment	\$40	■ Specialist copayment	\$40	■ Specialist copayment	\$40
■ Hospital (facility) coinsurance	20%	■ Hospital (facility) coinsurance	20%	■ Hospital (facility) coinsurance	20%
■ Other coinsurance	0%	■ Other coinsurance	0%	■ Other coinsurance	0%
<p>This EXAMPLE event includes services like:</p> <p>Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>)</p>		<p>This EXAMPLE event includes services like:</p> <p>Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)</p>		<p>This EXAMPLE event includes services like:</p> <p>Emergency room care (<i>including medical supplies</i>) Diagnostic test (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>)</p>	
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
Cost Sharing		Cost Sharing		Cost Sharing	
Deductibles	\$500	Deductibles	\$500	Deductibles	\$500
Copayments	\$10	Copayments	\$600	Copayments	\$600
Coinsurance	\$2,100	Coinsurance	\$60	Coinsurance	\$100
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$60	Limits or exclusions	\$20	Limits or exclusions	\$0
The total Peg would pay is	\$2,670	The total Joe would pay is	\$1,180	The total Mia would pay is	\$1,200

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

Language Access Services:

(TTY/TDD: 711)

Albanian (Shqip): Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (833) 639-1634

Amharic (አማርኛ): ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በገና የማግኘት ሙብት አለዎት። አስተርጓሚ ለማናገር (833) 639-1634 ይደውሉ።

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (833) 639-1634.

Armenian (հայերեն): Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (833) 639-1634:

Bassa (Bàsɔ̀ Wùdù): M̄ dyi dyi-diè-djè b̄é b̄édjé b̄á céè-djè nià ke dyí ní, ɔ̀ m̀ò nì dyí-b̄édjèin-djè b̄é m̀ ké gbo-kpá-kpá kè b̄ǎ kpǎ djé m̀ b̄ídjí-wùdùùn b̄ó pídyi. B̄é m̀ ké wuɖu-zìin-nyò d̀ò gbo wùdù ke, d̄á (833) 639-1634.

Bengali (বাংলা): যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (833) 639-1634 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖု (833) 639-1634 သို့ ခေါ်ဆိုပါ။

Chinese (中文): 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(833) 639-1634。

Dinka (Dinka): Na nɔŋ thiëc në ke de yä thorë, ke yin nɔŋ loŋ bē yi kuony ku wër alëu bē gɛɛr yic yin ne thoŋ du ke cin wëu tääuë ke piny. Te kør yin ba jam wënë ran ye thok geryic, ke yin cəl (833) 639-1634.

Dutch (Nederlands): Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (833) 639-1634.

Farsi (فارسي): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه‌ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (833) 639-1634 تماس بگیرید.

Language Access Services:

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (833) 639-1634.

German (Deutsch): Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (833) 639-1634.

Greek (Ελληνικά) Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (833) 639-1634.

Gujarati (ગુજરાતી): જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો (833) 639-1634.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (833) 639-1634.

Hindi (हिंदी): अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें (833) 639-1634 ।

Hmong (White Hmong): Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (833) 639-1634.

Igbo (Igbo): O bur u na i nwere ajuju o buła gbasara akwukwo a, i nwere ikike inweta enyemaka na ozi n'asusu gi na akwughị ugwo o buła. Ka gi na okowa okwu kwuo okwu, kpoo (833) 639-1634.

Ilokano (Ilokano): Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (833) 639-1634.

Indonesian (Bahasa Indonesia): Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi (833) 639-1634.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (833) 639-1634

Japanese (日本語): この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(833) 639-1634 にお電話ください。

Language Access Services:

Khmer (ខ្មែរ): បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។
ដើម្បីជ្រកជាមួយអ្នកបកប្រែ សូមហៅ(833) 639-1634 ។

Kirundi (Kirundi): Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (833) 639-1634.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(833) 639-1634 로 문의하십시오.

Lao (ພາສາລາວ): ຖ້າທ່ານມີຄໍາຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ.
ເພື່ອໂອ້ນລັບກັບວ່າມແປພາສາ, ໃຫ້ໂທຫາ (833) 639-1634.

Navajo (Diné): Dii naaltsoos biká'ígíí lahgo bina'idiłkígdgo ná bohónéedzǎ dóó bee ahóót'i' t'áá ni nizaad k'ehjı́ bee nił hodoonih t'áadoo bááh ilínígóó.
Ata' halne'ígíí la' bich'ı́' hadeesdzih nínizingo kojı́' hodiılneh (833) 639-1634.

Nepali (नेपाली): यदि यो कागजातबारे तपाईंसँग केही प्रश्नहरू छन् भने, आफ्नै भाषामा निःशुल्क सहयोग तथा जानकारी प्राप्त गर्न पाउने हक तपाईंसँग छ।
दोभाषेसँग कुरा गर्नका लागि, यहाँ कल गर्नुहोस् (833) 639-1634

Oromo (Oromifaa): Sanadi kanaa wajjin walqabaate gaffi kamiyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (833) 639-1634 bilbilla.

Pennsylvania Dutch (Deutsch): Wann du Frooge iwwer selle Document hoscht, du hoscht die Recht um Hilfe un Information zu griege in dei Schprooch mitaus Koscht. Um mit en Iwwersetze zu schwetze, ruff (833) 639-1634 aa.

Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer (833) 639-1634.

Portuguese (Português): Se tiver quaisquer dúvidas acerca deste documento, tem o direito de solicitar ajuda e informações no seu idioma, sem qualquer custo. Para falar com um intérprete, ligue para (833) 639-1634.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਬਾਸੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ(833) 639-1634 ਤੇ ਕਾਲ ਕਰੋ।

Language Access Services:

Romanian (Română): Dacă aveți întrebări referitoare la acest document, aveți dreptul să primiți ajutor și informații în limba dumneavoastră în mod gratuit. Pentru a vă adresa unui interpret, contactați telefonic (833) 639-1634.

Russian (Русский): Если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (833) 639-1634.

Samoan (Samoa): Afai e iai ni ou fesili e uiga i lenei tusi, e iai lou 'aia e maua se fesoasoani ma faamatalaga i lou lava gagana e aunoa ma se totogi. Ina ia talanoa i se tagata faaliliu, vili (833) 639-1634.

Serbian (Srpski): Ukoliko imate bilo kakvih pitanja u vezi sa ovim dokumentom, imate pravo da dobijete pomoć i informacije na vašem jeziku bez ikakvih troškova. Za razgovor sa prevodiocem, pozovite (833) 639-1634.

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (833) 639-1634.

Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (833) 639-1634.

Thai (ไทย): หากท่านมีคำถามใดๆ เกี่ยวกับเอกสารฉบับนี้ ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่านโดยไม่มีค่าใช้จ่าย โดยโทร (833) 639-1634 เพื่อพูดคุยกับล่าม

Ukrainian (Українська): якщо у вас виникають запитання з приводу цього документа, ви маєте право безкоштовно отримати допомогу й інформацію вашою рідною мовою. Щоб отримати послуги перекладача, зателефонуйте за номером (833) 639-1634.

Urdu (اردو): اگر اس دستاویز کے بارے میں آپ کا کوئی سوال ہے، تو آپ کو مدد اور اپنی زبان میں مفت معلومات حاصل کرنے کا حق حاصل ہے۔ کسی مترجم سے بات کرنے کے لئے، (833) 639-1634 پر کال کریں۔

Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (833) 639-1634.

(Yiddish) (אידיש): אויב איר האט שאלות וועגן דעם דאקומענט, האט איר די רעכט צו באקומען דעם אינפארמאציע אין אייער שפראך אהן קיין פרייז. צו רעדן צו אן איבערזעצער, רופט (833) 639-1634.

Yoruba (Yorùbá): Tí o bá ní èyíkéyí ìbèrè nípa àkọsílẹ̀ yí, o ní ètọ́ láti gba ìrànwọ́ àti ìwífún ní èdè rẹ̀ lẹ́fẹ́. Bá wa ògbùfọ̀ kan sọrọ̀, pe (833) 639-1634.

Language Access Services:

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

CEBCO: Hancock County HSA E2



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, <https://eoc.anthem.com/eocdps/aso>. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call (855) 603-7982 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$3,000/single or \$6,000/family for In- Network Providers . \$6,000/single or \$12,000/family for Non-Network Providers .	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible ?	Yes. Preventive Care . Children’s eye exam. For more information see below.	This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	\$5,000/single or \$10,000/family for In- Network Providers . \$10,000/single or \$20,000/family for Non-Network Providers .	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Non- Network Transplant Services, Premiums , balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don’t count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. Blue Access. See www.anthem.com or call (855) 603-7982 for a list of network providers . Costs may vary by site of service and how the provider bills.	This plan uses a provider network . You will pay less if you use a provider in the plan’s network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware, your network provider might use an Out-of-Network Provider for some services (such as lab work). Check with your provider before you get

		services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral .

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In- Network Provider (You will pay the least)	Non- Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	Virtual visits (Telehealth) benefits available.
	Specialist visit	20% coinsurance	40% coinsurance	Virtual visits (Telehealth) benefits available.
	Preventive care / screening / immunization	No charge	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	-----none-----
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	-----none-----
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://www.anthem.com/pharmacyinformation/	Tier 1 - Typically Generic	20% coinsurance (retail and home delivery)	Not covered (retail and home delivery)	For more information, refer to "National Drug List" at http://www.anthem.com/pharmacyinformation/ *See Prescription Drug section
	Tier 2 - Typically Preferred Brand & Non-Preferred Generic Drugs	20% coinsurance (retail and home delivery)	Not covered (retail and home delivery)	
	Tier 3 - Typically Non-Preferred Brand and Generic drugs	20% coinsurance (retail and home delivery)	Not covered (retail and home delivery)	
	Tier 4 - Typically Preferred Specialty (brand and generic)	20% coinsurance (retail and home delivery)	Not covered (retail and home delivery)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	-----none-----
	Physician/surgeon fees	20% coinsurance	40% coinsurance	-----none-----
If you need immediate medical attention	Emergency room care	20% coinsurance	Covered as In- Network	-----none-----
	Emergency medical transportation	20% coinsurance	Covered as In- Network	-----none-----
	Urgent care	20% coinsurance	40% coinsurance	-----none-----

* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/aso>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In- <u>Network</u> Provider (You will pay the least)	Non- <u>Network</u> Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	100 days/benefit period for Inpatient physical medicine, rehabilitation including day rehabilitation programs and skilled nursing services combined
	Physician/surgeon fees	20% coinsurance	40% coinsurance	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit 20% coinsurance Other Outpatient 20% coinsurance	Office Visit 40% coinsurance Other Outpatient 40% coinsurance	Office Visit Virtual visits (Telehealth) benefits available. Other Outpatient -----none-----
	Inpatient services	20% coinsurance	40% coinsurance	-----none-----
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	100 visits/benefit period, including private duty nursing
	Rehabilitation services	20% coinsurance	40% coinsurance	*See Therapy Services section.
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	100 days/benefit period for Inpatient physical medicine, rehabilitation including day rehabilitation programs and skilled nursing services combined
	Durable medical equipment	20% coinsurance	40% coinsurance	*See Durable Medical Equipment Section
	Hospice services	20% coinsurance	40% coinsurance	-----none-----
If your child needs dental or eye care	Children's eye exam	No charge	40% coinsurance	*See Vision Services section
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	-----none-----

* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/aso>.

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- Cosmetic surgery
- Glasses for a child
- Long-term care
- Dental care (Adult)
- Hearing Aids
- Routine foot care unless you have been diagnosed with diabetes
- Dental Check-up
- Infertility treatment
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Acupuncture
- Most coverage provided outside the United States. See www.bcbsglobalcore.com
- Bariatric surgery for In-[Network Providers](#)
- Private-duty nursing 100 visits/benefit period including [home health care](#).
- Chiropractic care 12 visits/benefit period
- Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Ohio Department of Insurance, 50 W. Town Street, Third Floor - Suite 300, Columbus, Ohio 43215, (800) 686-1526, (614) 644-2673, Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, www.cciio.cms.gov. Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact:

ATTN: Grievances and Appeals, P.O. Box 105568, Atlanta GA 30348-5568

Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, www.cciio.cms.gov

Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/aso>.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$3,000
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
[Diagnostic tests](#) (*ultrasounds and blood work*)
[Specialist](#) visit (*anesthesia*)

Total Example Cost	\$12,700
---------------------------	-----------------

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$3,000
Copayments	\$0
Coinsurance	\$1,900
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$4,960

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$3,000
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)
[Diagnostic tests](#) (*blood work*)
[Prescription drugs](#)
[Durable medical equipment](#) (*glucose meter*)

Total Example Cost	\$5,600
---------------------------	----------------

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$3,000
Copayments	\$0
Coinsurance	\$500
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$3,520

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$3,000
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)
[Diagnostic test](#) (*x-ray*)
[Durable medical equipment](#) (*crutches*)
[Rehabilitation services](#) (*physical therapy*)

Total Example Cost	\$2,800
---------------------------	----------------

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$2,800
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

Language Access Services:

(TTY/TDD: 711)

Albanian (Shqip): Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (855) 603-7982

Amharic (አማርኛ): ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በገና የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (855) 603-7982 ይደውሉ።

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (855) 603-7982.

Armenian (հայերեն): Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (855) 603-7982:

Bassa (Bàsɔ̀ Wùdù): M̄ dyi dyi-diè-djè b̄é b̄édjé b̄á céè-djè nià ke dyí ní, ɔ̀ m̀ò nì dyí-b̄édjèin-djè b̄é m̀ ké gbo-kpá-kpá kè b̄ǎ kpǎ djé m̀ b̄ídjí-wùdùùn b̄ó pídyi. B̄é m̀ ké wuɖu-zìin-nyò d̀ò gbo wùdù ke, d̄á (855) 603-7982.

Bengali (বাংলা): যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (855) 603-7982 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖု (855) 603-7982 သို့ ခေါ်ဆိုပါ။

Chinese (中文): 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(855) 603-7982。

Dinka (Dinka): Na nɔŋ thiëc në ke de yä thorë, ke yin nɔŋ loŋ bē yi kuony ku wër alëu bē gɛɛr yic yin ne thoŋ du ke cin wëu tāäuë ke piny. Te kør yin ba jam wënë ran ye thok geryic, ke yin cəl (855) 603-7982.

Dutch (Nederlands): Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (855) 603-7982.

Farsi (فارسي): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه‌ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (855) 603-7982 تماس بگیرید.

Language Access Services:

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (855) 603-7982.

German (Deutsch): Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (855) 603-7982.

Greek (Ελληνικά) Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (855) 603-7982.

Gujarati (ગુજરાતી): જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો (855) 603-7982.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (855) 603-7982.

Hindi (हिंदी): अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें (855) 603-7982 ।

Hmong (White Hmong): Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (855) 603-7982.

Igbo (Igbo): O bur u na i nwere ajuju o buła gbasara akwukwo a, i nwere ikike inweta enyemaka na ozi n'asusu gi na akwughị ugwo o buła. Ka gi na okowa okwu kwuo okwu, kpoo (855) 603-7982.

Ilokano (Ilokano): Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (855) 603-7982.

Indonesian (Bahasa Indonesia): Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi (855) 603-7982.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (855) 603-7982

Japanese (日本語): この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(855) 603-7982 にお電話ください。

Language Access Services:

Khmer (ខ្មែរ): បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។
ដើម្បីជ្រកជាមួយអ្នកបកប្រែ សូមហៅ(855) 603-7982 ។

Kirundi (Kirundi): Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (855) 603-7982.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(855) 603-7982 로 문의하십시오.

Lao (ພາສາລາວ): ຖ້າທ່ານມີຄໍາຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ.
ເພື່ອໂອ້ນລັບກ່ຽວກັບພາສາ, ໃຫ້ໂທຫາ (855) 603-7982.

Navajo (Diné): Dii naaltsoos bika'ígíí lahgo bina'idílkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bááh ilínígóó.
Ata' halne'ígíí la' bich'í' hadeesdzih nínizingo kojí' hodiilnih (855) 603-7982.

Nepali (नेपाली): यदि यो कागजातबारे तपाईंसँग केही प्रश्नहरू छन् भने, आफ्नै भाषामा निःशुल्क सहयोग तथा जानकारी प्राप्त गर्न पाउने हक तपाईंसँग छ।
दोभाषेसँग कुरा गर्नका लागि, यहाँ कल गर्नुहोस् (855) 603-7982

Oromo (Oromifaa): Sanadi kanaa wajjin walqabaate gaffi kamiyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (855) 603-7982 bilbilla.

Pennsylvania Dutch (Deutsch): Wann du Frooge iwwer selle Document hoscht, du hoscht die Recht um Hilfe un Information zu griege in dei Schprooch mitaus Koscht. Um mit en Iwwersetze zu schwetze, ruff (855) 603-7982 aa.

Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer (855) 603-7982.

Portuguese (Português): Se tiver quaisquer dúvidas acerca deste documento, tem o direito de solicitar ajuda e informações no seu idioma, sem qualquer custo. Para falar com um intérprete, ligue para (855) 603-7982.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਬਾਸੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ(855) 603-7982 ਤੇ ਕਾਲ ਕਰੋ।

Language Access Services:

Romanian (Română): Dacă aveți întrebări referitoare la acest document, aveți dreptul să primiți ajutor și informații în limba dumneavoastră în mod gratuit. Pentru a vă adresa unui interpret, contactați telefonic (855) 603-7982.

Russian (Русский): Если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (855) 603-7982.

Samoan (Samoa): Afai e iai ni ou fesili e uiga i lenei tusi, e iai lou 'aia e maua se fesoasoani ma faamatalaga i lou lava gagana e aunoa ma se totogi. Ina ia talanoa i se tagata faaliliu, vili (855) 603-7982.

Serbian (Srpski): Ukoliko imate bilo kakvih pitanja u vezi sa ovim dokumentom, imate pravo da dobijete pomoć i informacije na vašem jeziku bez ikakvih troškova. Za razgovor sa prevodiocem, pozovite (855) 603-7982.

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (855) 603-7982.

Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (855) 603-7982.

Thai (ไทย): หากท่านมีคำถามใดๆ เกี่ยวกับเอกสารฉบับนี้ ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่านโดยไม่มีค่าใช้จ่าย โดยโทร (855) 603-7982 เพื่อพูดคุยกับล่าม

Ukrainian (Українська): якщо у вас виникають запитання з приводу цього документа, ви маєте право безкоштовно отримати допомогу й інформацію вашою рідною мовою. Щоб отримати послуги перекладача, зателефонуйте за номером (855) 603-7982.

Urdu (اردو): اگر اس دستاویز کے بارے میں آپ کا کوئی سوال ہے، تو آپ کو مدد اور اپنی زبان میں مفت معلومات حاصل کرنے کا حق حاصل ہے۔ کسی مترجم سے بات کرنے کے لئے، (855) 603-7982 پر کال کریں۔

Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (855) 603-7982.

(Yiddish) (אידיש): אויב איר האט שאלות וועגן דעם דאקומענט, האט איר די רעכט צו באקומען דעם אינפארמאציע אין אייער שפראך אהן קיין פרייז. צו רעדן צו אן איבערזעצער, רופט (855) 603-7982.

Yoruba (Yorùbá): Tí o bá ní èyíkéyí ìbèrè nípa àkọsílẹ̀ yí, o ní ètọ́ láti gba ìrànwọ́ àti ìwífún ní èdè rẹ̀ lọfẹ́fẹ́. Bá wa ògbùfọ̀ kan sọrọ̀, pe (855) 603-7982.

Language Access Services:

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

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.

2023 County Contribution Single:

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

2023 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 PortfolioSM** – 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](https://www.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.



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

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

Examples include, but are not limited to:

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

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

hsabank
own your health.

Dental Benefits

effective on first of the month following date of employment



**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 Plan Pays	Delta Dental Premier® Dentist Plan Pays	Nonparticipating Dentist 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.

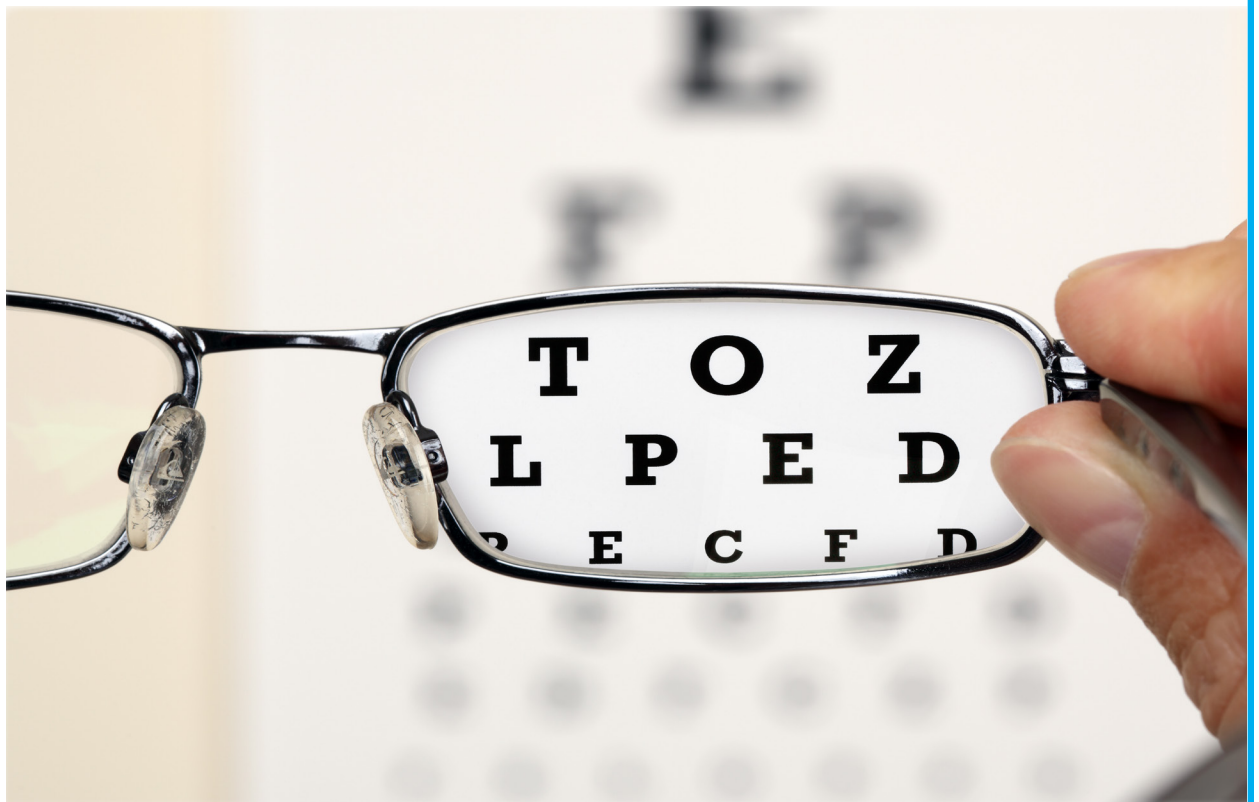
Dependents choosing this plan are required to remain enrolled for a period of 12 months. Should a Dependent choose to drop coverage after that time, he or she may not re-enroll prior to the date on which 12 months have elapsed. An election may be revoked or changed at any time if the change is the result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

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.



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

Shop online and connect your benefits.



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](https://www.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.

vsp
vision care

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](https://www.vsp.com/offers).

+

Up to
40%
Savings on
lens enhancements[‡]

Create an account today.

Contact us: **800.877.7195** or [vsp.com](https://www.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



BENEFIT	DESCRIPTION	COPAY	FREQUENCY
Your Coverage with a VSP Provider			
WELLVISION EXAM	<ul style="list-style-type: none"> Focuses on your eyes and overall wellness 	\$10	Every 12 months
ESSENTIAL MEDICAL EYE CARE	<ul style="list-style-type: none"> 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*	<ul style="list-style-type: none"> \$140 featured frame brands allowance \$120 frame allowance 20% savings on the amount over your allowance 	Included in Prescription Glasses	Every 12 months
LENSES	<ul style="list-style-type: none"> Single vision, lined bifocal, and lined trifocal lenses Impact-resistant lenses for dependent children 	Included in Prescription Glasses	Every 12 months
LENS ENHANCEMENTS	<ul style="list-style-type: none"> 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)	<ul style="list-style-type: none"> \$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 <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> No more than a \$39 copay on routine retinal screening as an enhancement to a WellVision Exam 		
	Laser Vision Correction <ul style="list-style-type: none"> 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](https://www.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.
 ©2022 Vision Service Plan. All rights reserved.
 VSP, Eyeconic, and WellVision Exam are registered trademarks of Vision Service Plan. Flexon and Dragon are registered trademarks of Marchon Eyewear, Inc. All other brands or marks are the property of their respective owners. 102898 VCCM
 Classification: Restricted

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.

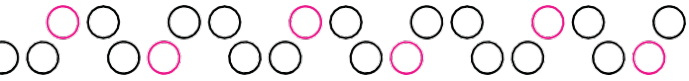


Flexible Spending Account



•solved Benefit Services

•solved Benefit Services



Dear Employees:

We are excited to tell you about a great benefit 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 these 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.



Know Your Eligible and Ineligible Expenses

Estimated unreimbursed health care 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
- 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

- Doula*
- 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

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

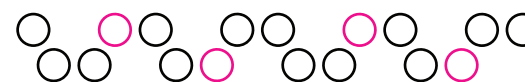
Electrolysis

Swimming lessons

Cosmetic surgery/procedures

Marriage or career counseling

Sunscreen (SPF less than 15 needs RX)



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.

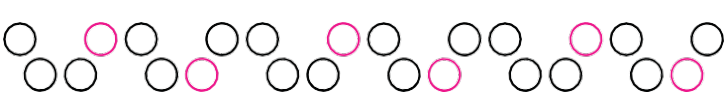
Monthly income before taxes	Without 125 Plan	With 125 Plan
	\$2,200.00	\$2,200.00
Pre-tax salary deductions		
Health FSA contribution	\$0.00	\$60.00
Dependent Care FSA contribution	\$0.00	\$260.00
Employee contribution to health plan	\$0.00	\$50.00
Total	\$0.00	\$370.00
Payroll taxes	\$168.30	\$140.00
FICA (7.65%)	\$267.52	\$222.53
Federal income tax(12.16%)	\$88.00	\$73.20
State income tax (4%)		
Total	\$523.82	\$435.73
After tax expenses	\$60.00	\$0.00
Health care expenses	\$260.00	\$0.00
Dependent care expenses	\$50.00	\$0.00
Employee contribution to health plan		
Total	\$370.00	\$0.00
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 866-370-3040.

Enrollment

How do I enroll?

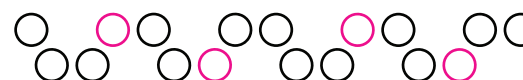
To enroll in either or both the Health and Dependent Care FSA, you simply need to fill out the Enrollment Form before the beginning of each Plan Year.

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 www.isolvedbenefitservices.com.

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 \$570 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. Remember to attach supporting documentation for the claim. This information can be faxed to 800-379-5670.

You may also submit your claim by mail: isolved Benefit Services, Inc., PO Box 488, Coldwater, MI 49036

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. 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. Simply choose Flexible Spending Account/Health Reimbursement under Employee/Participants and follow the on-screen instructions.
- 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 quarterly during the Plan year. 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 a 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:

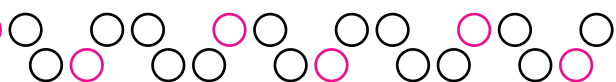
1. If the request was for more than the balance of your account.

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.



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.

FSA worksheet

Estimated unreimbursed health care expenses

Medical	Annual amount	Vision	Annual amount
Deductible	_____	Deductible	_____
Coinsurance payment	_____	Coinsurance payment	_____
Contraceptives	_____	Contact lenses	_____
Doctor's office visits	_____	Contact solutions	_____
Immunizations	_____	Examinations	_____
Insulin	_____	Frames	_____
Laboratory tests	_____	Laser eye surgery	_____
Other expenses	_____	Lenses	_____
Over-the-counter medicine ¹	_____		
Physicals/annual checkups	_____		
Prescription drugs	_____		
Splints, supports,	_____		
Corrective devices	_____		
Therapy treatments	_____		
(medical reasons only)			
Well-baby care	_____		
	Subtotal _____		
		Subtotal _____	
		Total _____	
		Dependent Day Care	Annual amount
		(necessary for you and your spouse to work)	
		After-school care	_____
		Care of other	_____
		dependents	_____
		Childcare/	_____
		day care center	_____
		Childcare in home	_____
		Preschool	_____
		Total ²	_____
Dental	Annual amount		
Deductible	_____		
Coinsurance payment	_____		
Cleaning dentures	_____		
Fillings/crowns/bridges	_____		
Fluoride treatments	_____		
Orthodontia	_____		
(medical reasons only)			
X-rays	_____		
	Subtotal _____		

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.

¹Effective 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).

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

Required Notices





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

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 you 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: 08/01/2022
 Name of Entity/Sender: CEBCO Health and Wellness Program
 Address: 209 E. State Street Columbus, OH 43215
 Phone Number: 888-757-1904



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 consultation with the attending physician and the patient, for:

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

These benefits will be provided subject to the same 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.)



2022-23 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 to 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 chooses 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 will also be asked to complete a comprehensive biometric screening, which will include a blood test for glucose, kidney function, liver function, cholesterol, and a complete blood count, among others. You are not required to complete the HRA or to participate in the biometric screening or any other activity offered through the wellness program.

Should you/your spouse choose to participate, the information from your HRA and the results from your biometric screening 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 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
<p>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</p>	<p>Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711</p> <p>Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711</p>
INDIANA-Medicaid	MASSACHUSETTS-Medicaid and CHIP
<p>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</p>	<p>Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840</p>
IOWA-Medicaid and CHIP (Hawki)	MINNESOTA-Medicaid
<p>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</p>	<p>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</p>
KANSAS-Medicaid	MISSOURI-Medicaid
<p>Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884</p>	<p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>
KENTUCKY-Medicaid	MONTANA-Medicaid
<p>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</p> <p>KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718</p> <p>Kentucky Medicaid Website: https://chfs.ky.gov</p>	<p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084</p>
LOUISIANA-Medicaid	NEBRASKA-Medicaid
<p>Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>	<p>Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178</p>

NEVADA-Medicaid	SOUTH CAROLINA-Medicaid
Medicaid Website: http://dhcftp.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.cohhs.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.**

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 2023 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, 2022, for coverage starting as early as Jan. 1, 2023.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards.

If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.12 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.