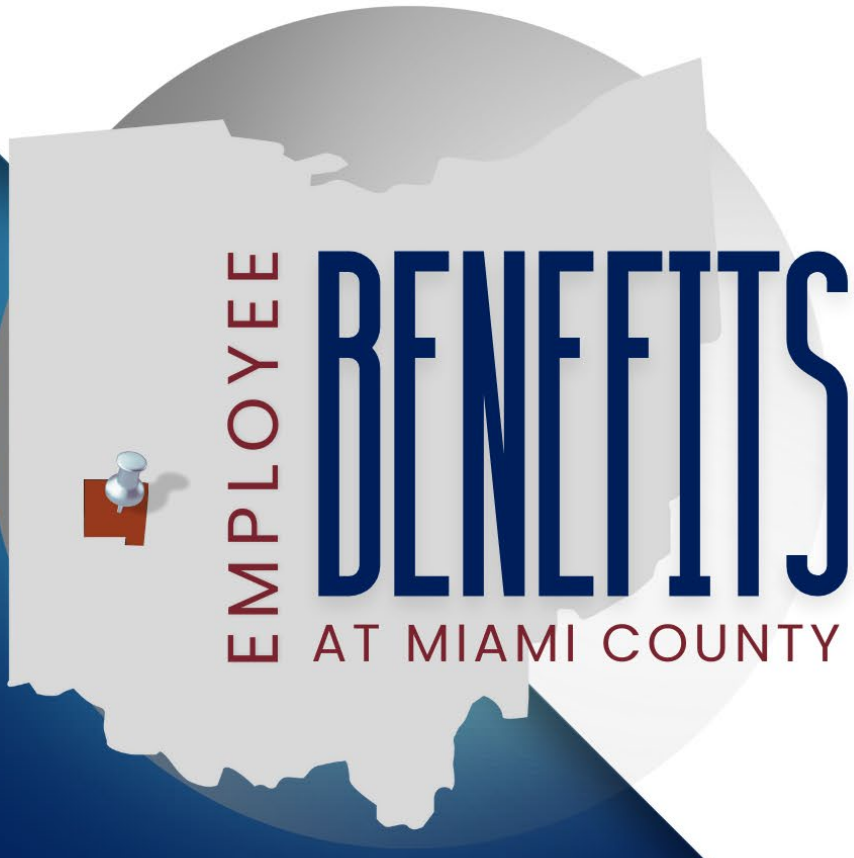

EMPLOYEE BENEFITS GUIDE 2025

A MESSAGE FROM HUMAN RESOURCES

Welcome to Miami County! 

In the fall of 2024, the Board of Miami County Commissioners approved the first renewal contract with CEBCO, the consortium to which we belong for health insurance. This partnership has allowed the County to continue to provide affordable benefits with a 4.1% health insurance renewal for 2025 during a time in which the national trend is at least 8%.

All benefits listed in this guide are effective January 1, 2025. This guide contains important information about your benefit choices, eligibility, and the enrollment process. I encourage you to review this guide carefully as you make decisions about which plans are best for you and your family. Please contact a member of your Human Resources team with any questions.

I am so incredibly appreciative of the hard work that has been put into the plan renewals by the Commissioners, the Insurance Committee, and our benefits broker, Benefits Analysis Corporation.

On behalf of the Board of Miami County Commissioners and the Miami County Insurance Committee, we wish you and your family continued health and well-being throughout the year.

Angela Lewis
Human Resources Director
Board of Miami County Commissioners

This packet is intended to provide a brief overview of your employee benefits. If there is a discrepancy between the enclosed documents and the certificate of coverage, the certificate of coverage for each plan will be the final determining document.

Employees within the office of another Elected Official or within a collective bargaining unit should note that some of the information contained herein may not apply to you due to specific conditions included in your individual agreement and/or department policies. Please refer to your Department Head or Collective Bargaining Agreement for specific information.

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ELIGIBILITY

Rates and plans included in this guide will be effective on January 1, 2025 and remain in effect through December 31, 2025.
You must complete your benefit enrollments within 30 days of your start date with Miami County.

ENROLLMENT PERIODS

NEW HIRE ELIGIBILITY	QUALIFYING LIFE EVENTS	OPEN ENROLLMENT
As a newly hired or rehired benefits-eligible employee, you have 30 calendar days to enroll in benefits. After this time, changes can only be made with a qualifying life event.	You have 30 calendar days to make changes to your benefits if you experience a qualifying life event such as marriage, birth/adoption, divorce, or gaining or losing other coverage.	Open Enrollment gives you the opportunity to review and make changes to your benefits and covered dependents.
EFFECTIVE DATE		
First day of the month following 30 calendar days of employment.	Date of Qualifying Life Event	Open Enrollment elections become effective on January 1.

REQUIRED DOCUMENTATION
If you are enrolling family members in a benefit plan due to a Qualifying Life Event, the following documentation must be uploaded during the UKG enrollment process. Contact HR if you have difficulty uploading the documentation.
SPOUSE
Social Security card ***and*** one of the following: Marriage License Copy of the first page of your previous year tax return showing "Married Filed Jointly" or "Married Filing Separately"
CHILD(REN)
Social Security card ***and*** the following: Biological Children*:* Birth Certificate Adoption/Guardianship: Court documents placing child with you Step-Children: Legal marriage document & child's birth certificate Court-Ordered Dependents: Court order establishing responsibility to provide dependent health insurance coverage

You are eligible to elect the benefits in this guide if you are a full-time employee in a benefits-eligible position or limited benefits if you are a part-time employee in a benefits-eligible position working on average 20 or more hours per week. Employees in temporary or seasonal positions are not eligible for benefits.

Employees who have elected coverage in a benefit plan may enroll their legal spouse and dependent children up to age 26 regardless of marital or student status, including:

- Son, daughter, stepson, or stepdaughter
- Legally adopted child
- Legally placed foster child
- Disabled child age 26 or older upon approval
- Child placed by an authorized agency or by judgement, decree, or other court order

ELIGIBILITY & WHEN BENEFITS BEGIN AND END

BENEFIT	MINIMUM HOURS / WEEK WORKED TO BE ELIGIBLE	WHO PAYS		BENEFIT BEGINS		CHANGES ACCEPTED		BENEFIT ENDS		
		County	You	Hire Date	1st of Month after 30 Days	Life Event	Open Enrollment	Last Day Worked	End of Month Worked	COBRA Eligible
Medical (*Dependents to age 26)*	30 hours	●	●		●	●	●		●	●
HSA Contribution	30 hours	●			●	●	●	●		
Voluntary HSA Contribution	30 hours		●		●	Anytime		●		
Flex Spending: Healthcare	30 hours		●		●	●	●	●		
Flex Spending: Dependent Care	30 hours		●		●	●	●	●		
Dental *(Dependents to age 26)*	30 hours		●		●	●	●		●	●
Vision (*Dependents to age 26)*	30 hours		●		●	●	●		●	●
Basic Life & AD&D	30 hours	●			●	●	●	●		
Voluntary Life & AD&D	30 hours		●		●	●	●	●		
Employee Assistance Program	N/A	●		●		●	●	●		
OPERS	N/A	●	●	●		●	●	●		
Deferred Compensation	N/A		●	●		●	●	●		
YMCA	N/A	●	●	●		Anytime			●	
Lincoln Community Center	N/A	●		●		Anytime			●	
Aflac	N/A		●		●	Anytime			●	

MEDICARE

Medicare is health insurance for people 65+, and some people under 65 with certain disabilities or conditions. Enrollment can occur three months prior to your 65th birthday or upon loss of other health insurance coverage, such as an employer plan. Medicare only offers individual coverage and does not offer plans for spouses or dependents. If you maintain health insurance through Miami County in addition to Medicare coverage, the County plan will be the primary payer.

When an employee first enrolls in Medicare, there are two primary coverage options:

ORIGINAL MEDICARE	MEDICARE ADVANTAGE (PART C)
Original Medicare includes Part A and Part B. Part A covers inpatient care in hospitals, hospice, home health care, etc. Part B covers services from doctors and other healthcare providers, including outpatient care, preventative services, durable medical equipment, etc.	Medicare Advantage is a Medicare-approved plan from a private company that offers an alternative to Original Medicare for your health and drug coverage. These "bundled" plans include Part A, Part B, and *usually* Part D.
You can join a separate Medicare drug plan to get Medicare drug coverage (Part D).	In most cases, you will need to use doctors who are in the plan's network.
You can use any doctor or hospital that takes Medicare, anywhere in the US.	Plans may have lower out-of-pocket costs than Original Medicare.
To help pay your out-of-pocket costs in Original Medicare (like your 20% co-insurance), you can also buy supplemental coverage, like Medicare Supplement Insurance (Medigap), or have coverage from a former employer, union, or Medicaid.	Plans may have some extra benefits that Original Medicare does not cover – like vision, hearing, and dental services.

To learn more or sign-up for Medicare, visit www.medicare.gov or call 1-800-633-4227.

Did you know that as a Miami County employee, you have access to no-cost, local resources to help with Medicare? Miami County's insurance broker, Benefits Analysis Corporation, is available to provide assistance and guidance with the Medicare process. Contact Michael Dugan at 937-335-5751 to schedule a personalized, one-on-one session.

CONTINUING COVERAGE UNDER COBRA

To help you continue your health coverage, Congress passed the Consolidated Omnibus Reconciliation Act (COBRA) in 1986. Under COBRA, you are eligible to purchase medical only, dental/vision only, or medical/dental/vision coverage under certain circumstances when your group health plan coverage with Miami County ends. If you are a Miami County employee and have medical, dental and/or vision coverage, you and your covered family members have the right to elect COBRA continuation coverage for up to 18 months if your coverage is lost because of one of these qualifying events:

- Your employment ends for a reason other than gross misconduct *or*
- Your work hours are reduced to the point where you no longer are eligible for benefits

The 18-month COBRA continuation period may be extended to 29 months if you or a family member (who is a qualified beneficiary) is disabled according to Social Security at the time of one of the above qualifying events. This 11-month extension is available to all qualified beneficiaries who lose coverage due to termination of employment or a reduction of hours.

Covered family members have the right to choose COBRA continuation coverage for up to 36 months if coverage is lost for any of these qualifying events:

- Death of the employee
- Divorce or legal separation of the employee and spouse or dissolution of the
- Domestic partnership
- A child loses coverage (turns 26)

The Life and Disability plans have conversion options. Consult your plan documents for more information.

2025 PAYROLL DEDUCTIONS

Deductions are taken from the first and second paychecks of each month. There are two months with a third paycheck from which no benefit deductions are taken. These third payrolls are noted in the table below in bold with an asterisk.

Payroll deductions are taken one month in advance for all benefits except Aflac, HSA, and Flex Spending, which are taken for the current month. ***See the end of this guide for a printable 2025 Payroll Calendar.***

QUESTIONS?

Your HR team is here to help you 24/7 with any questions or concerns you may throughout open enrollment process. Using ASK HR, schedule an appointment to meet with an HR team member individually or submit your question and we will respond within 24 business hours.

Scan/click the QR code or click on the icon at any point in the UKG Open Enrollment module.

GLOSSARY

ALLOWED AMOUNT

This is the maximum payment the plan will pay for a covered health service. May also be called “eligible expense”, “payment allowance”, or “negotiated rate.”

APPEAL

A request that your health insurer or plan review a decision that denies a benefit or payment (either in whole or in part.)

BALANCE BILLING

When a provider bills you for the balance remaining on the bill that your plan does not cover. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider’s charge is $100 and the allowed amount is $40, the provider may bill you for the remaining $60. This happens most often when you see an out-of-network provider. A network provider may not balance bill you for covered services.

COPAY

A flat dollar amount paid for certain services. Your copay does not count toward your deductible or max out of pocket.

COINSURANCE

The split-cost percentage between the plan and the member for services after the deductible has been met. For example, if you have a 20% coinsurance after meeting your deductible, you will pay $40 for a covered service that costs $200.

DEDUCTIBLE

The amount you pay for covered healthcare services before your insurance plan starts to pay some or all of the covered charges. Deductibles reset on January 1. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles. (For example, if your deductible is $1,000, your plan will not pay anything until you have met your $1,000 deductible for covered health services subject to the deductible.)

DEPENDENT

Plans offered through Miami County allow employees to cover a dependent up to age 26, regardless of marital or student status, through the end of the month in which they turn 26. Children with disabilities who meet certain criteria may continue health coverage past age of 26 with proof of disability.

DIAGNOSTIC CARE

Diagnostic care given to diagnose or treat existing symptoms.

EMERGENCY MEDICAL CONDITION

An illness, injury, or symptom (including severe pain), or condition severe enough to risk serious danger to your health if you did not get medical attention right away. If you did not get immediate medical attention you could reasonably expect one of the following: 1) Your health would be put in serious danger; 2) You would have serious problems with bodily functions; or 3) You would have serious damage to any part or organ of your body.

FORMULARY

A list of drugs your plan covers. A formulary may include how much your share of the cost is for each drug. Your plan may put drugs in different cost-sharing levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and different cost-sharing amount will apply to each tier.

MEDICALLY NECESSARY

Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine.

NETWORK

Within the medical, dental and vision plans you have the freedom to use any provider. However, when you use an in-network provider, the amount you pay out-of-pocket will be based on a negotiated fee, which is usually lower than the actual charges. If you use a provider who is outside of the network, you may be responsible for paying the difference between the negotiated amount and what the provider originally billed.

OUT OF POCKET MAXIMUM

The amount of money you could pay during a plan year before insurance pays 100% of all covered services. Coinsurance does count toward your annual out of pocket maximum.

PLAN

Health coverage issued to you directly (individual plan) or through an employer, union, or other group sponsor (employer group plan) that provides for certain health care costs. Also called “health insurance plan,” “policy,” “health insurance policy,” or “health insurance.”

PREAUTHORIZATION

A decision by your health insurer or plan that a health care service, treatment plan, prescription drug, or durable medical equipment (DME) is medically necessary. Sometimes called “precertification” or “prior approval.” Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency.

PREMIUM

The amount you pay from your paycheck for your insurance.

PREVENTATIVE CARE

Routine care, such as an annual physical, intended to keep you healthy. A service is considered preventative if there are no signs of illness and no indication that diagnostic services or treatment are needed.

PROVIDER

An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The plan may require the provider to be licensed, certified, or accredited as required by state law.

SCREENING

A type of preventative care that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition.

SPECIALIST

A provider focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

SPECIALTY DRUG

A type of prescription drug that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a formulary.

UCR (Usual, Customary, and Reasonable)

The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

URGENT CARE

Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

EMPLOYEE BENEFITS SELF-SERVICE

The UKG site and application are available from any location. You do not need to be on Miami County's system. If you have not recently logged into UKG you will be prompted to set up your Two-Factor Authentication options.

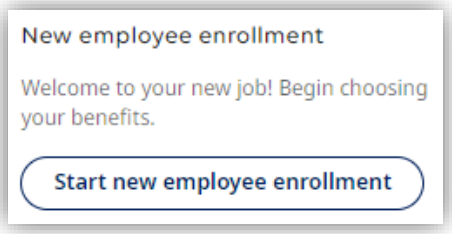
STEP 1. Log into UKG with your login credentials. Scan the QR code to the right or navigate to https://secure6.saashr.com/ta/6163172.login?rnd=ZUW&%40rtm=1

As a reminder, your User Name is your **First Initial + Last Initial + Last 4 Digits of Your Social Security Number**. *Example: Susie Hire 110-02-2023 = SH2023*

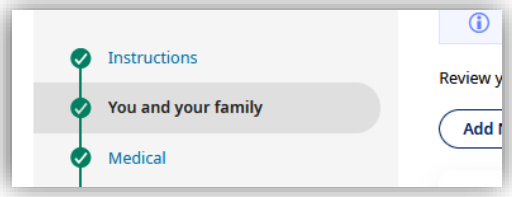
If you have forgotten your password, click **FORGOT PASSWORD** to reset it.

STEP 2. On the main page you will see **MY BENEFITS** on the left side of the screen.

Click on **START NEW EMPLOYEE ENROLLMENT** to begin the enrollment process,

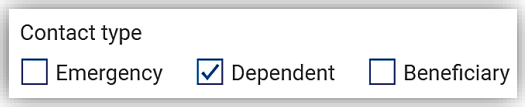


STEP 3. Next, review your contacts, dependents, and beneficiaries by clicking on **YOU AND YOUR FAMILY** is the place to update your contacts, dependents, and beneficiaries.



CONTACT TYPES

Each contact must have at least one box checked.



EMERGENCY Contact in case of an emergency

DEPENDENT This individual will be listed as a possible enrollee on your benefit plans

BENEFICIARY This individual will be listed as a possible beneficiary for life insurance and AD&D products

The following information must be included on all contacts:

- Birthdate
- Address
- Social Security Number
- Relationship
- Student Status

STEP 4. Review your benefit selections. You will have the option to keep all of your current elections.

HOW YOUR ANTHEM PLAN COVERS MEDICAL PROCEDURES

TAKE THE GUESSWORK OUT OF USING YOUR HEALTH PLAN THROUGH MIAMI COUNTY & CEBCO

If you're having a medical procedure done, Anthem can help you prepare. Knowing how your health plan benefits work and what's covered can help you save money and use your plan with confidence. Here's how.

TYPES OF CARE

How your health plan covers your procedure depends on why you're having it:

PREVENTATIVE CARE includes routine screening procedures, such as annual mammograms or colonoscopies. They're meant to catch issues early, before they become more serious. Your plan covers preventive procedures at 100% when you go to a care provider (doctor or other healthcare professional) in your plan's network. *You may also have out-of-pocket costs if the visit it to diagnose any issues and set a plan for treatment or more tests.*

DIAGNOSTIC CARE is when a doctor or specialist has suggested a procedure after they've diagnosed a health issue, such as a hip replacement or kidney stone removal. You are responsible for your share of the costs (coinsurance) and your deductible for this type of care.

QUICK TIPS

Anthem's **SMART SHOPPER** is a free tool that not only can help you save money on your procedure but it can also put money in your pocket! From the Sydney app on your phone or Anthem's website, go to **PROGRAMS** and then click on **SMART SHOPPER**. Once you click on **LEARN MORE**, you will be taken to the page with instructions on how to get started! You can also call them direct at 844-328-1582.

Smart Shopper is like your own personal assistant! They will help you understand your options and schedule your appointment. When you choose a provider that is know for high-quality outcomes, you can earn cash rewards! Once Anthem pays your claim, you will receive a check in the mail in about 6 – 8 weeks.

HOW YOUR PLAN WORKS WHEN YOU RECEIVE CARE

Some medical procedures require Anthem's preapproval first. Your doctor or specialist will take care of requesting the preapproval for you. You can follow up with your specialist or Anthem before your appointment to make sure approval was granted.

If your plan uses copays (the PPO plan), you'll pay a copay at the doctor's office or healthcare facility.

If your plan has a deductible and coinsurance (High-Deductible plan), you will have to meet your deductible before your health plan kicks in. Once you do, you and your plan will share costs of care.

After the procedure, you will get a bill from your care provider for your share of costs (coinsurance) – if there are any.

Once you reach your out-of-pocket maximum, your plan will cover 100% of the costs of care.

If you ever have cause to question the way a claim was paid, your first stop will be the insurance company. Anthem's claim processing team members are well-equipped to explain why a service was paid in a particular manner. The Anthem representatives have the most complete information regarding your claim. You also have the CEBCO team available for further review and clarification on difficult claims as well as the right to appeal how a claim was paid.

HEALTH INSURANCE PLANS

Miami County employees have a choice between a traditional embedded PPO plan and an embedded high deductible plan in 2025.

Both health insurance plans are offered through Anthem, through the county's partnership with CEBCO. Spouses are eligible for coverage, regardless of insurance available to them elsewhere.

The table to the right provides an overview of the in-network benefits available under the PPO and high deductible plan. Please see the plan documents or the following pages for more information on these plans, including out of network coverages.

The family deductibles and out-of-pocket maximums are embedded meaning the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum.

BENEFITS	PPO	HIGH DEDUCTIBLE
SINGLE		
Deductible	$500	$3,500
Max Out of Pocket	$2,500	$3,500
FAMILY		
Deductible	$1,000	$7,000
Max Out of Pocket	$5,000	$7,000
SERVICES		
Preventative Care	Covered in Full	Covered in Full
Primary Care	$20 Copay	Deductible then 0%
Specialist Care	$40 Copay	Deductible then 0%
Telehealth - Medical	Covered in Full	$59
Telehealth - Behavioral	Covered in Full	$80
Urgent Care	$50 Copay	Deductible then 0%
Emergency Room	$250	Deductible then 0%
Hospital	Deductible then 20%	Deductible then 0%
PRESCRIPTIONS		
30 Day		
Tier 1	$10	Deductible then 0%
Tier 2	$20	Deductible then 0%
Tier 3	$40	Deductible then 0%
90 Day		
Tier 1	$20	Deductible then 0%
Tier 2	$40	Deductible then 0%
Tier 3	$80	Deductible then 0%
Preventative Rx List	Not Applicable	Applicable

No one member will pay more than the individual deductible and individual out-of-pocket maximum.

Biweekly pre-tax payroll deductions are shown to the right for each plan and coverage tier available.
The Board of Miami County Commissioners pays approximately 86% of the monthly premiums for the high deductible plan and approximately 75% of the monthly premiums for the PPO plan. Payroll deductions for this benefit are taken only from the first and second payrolls of each month.

	PPO	HSA
Rate per Check	**You Pay**	**You Pay**
Employee	$94.23	$50.08
Employee + Child(ren)	$169.26	$89.97
Employee + Spouse	$207.58	$110.29
Family	$282.56	$150.20

Your summary of benefits

HIGH-DEDUCTIBLE ("HSA") PLAN

CEBCO

Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Blue Access CEBCO Miami County PPO HSA Plan E1

Your Network: Blue Access **Effective Date: 1/1/2025**

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	No charge after deductible is met
Mental Health & Substance Use Disorder Services	No charge after deductible is met
Specialist care	0% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible	$3,500 person / $7,000 family	$7,000 person / $14,000 family
Overall Out-of-Pocket Limit	$3,500 person / $7,000 family	$14,000 person / $28,000 family
EMBEDDED: The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per person deductible or per person out-of-pocket limit. All medical deductibles, copayments and coinsurance apply to the out-of-pocket limit (excluding Out-of-Network Human Organ and Tissue Transplant (HOTT), Cellular and Gene Therapy services). In-Network and Out-of-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.		
Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP).*		
Primary Care (PCP) and Mental Health and Substance Use Disorder Services *virtual and office*	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Specialist Care *virtual and office*	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Other Practitioner Visits **Maternity Doctor services** (prenatal/postnatal care and delivery)	0% coinsurance after deductible is met	20% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Other Services in an Office		
Allergy Testing	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Prescription Drugs *Dispensed in the office*	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Surgery	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Preventive care / screenings / immunizations	No charge	20% coinsurance after deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	20% coinsurance after deductible is met
Diagnostic Services		
Lab		
Office	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	20% coinsurance after deductible is met
X-Ray		
Office	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Emergency Room Facility Services	0% coinsurance after deductible is met	Covered as In-Network

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Emergency Room Doctor and Other Services	0% coinsurance after deductible is met	Covered as In-Network
Ambulance	0% coinsurance after deductible is met	Covered as In-network
Outpatient Mental Health and Substance Use Disorder Services at a Facility		
Facility Fees	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Doctor Services	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Physician and other services *including surgeon fees*		
Hospital	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)		
Facility Fees	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Human Organ and Tissue Transplants *Cornea transplants are treated the same as any other illness and subject to the medical benefits.*	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Physician and other services *including surgeon fees*	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Home Health Care *Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.*	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.* *Coverage for occupational therapy is limited to 30 visits per benefit period, physical therapy is limited to 30 visits per benefit period and speech therapy is limited to 20 visits per benefit period.*		
Office	0% coinsurance after deductible is met	20% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Outpatient Hospital	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Manipulation Therapy *office and outpatient hospital Coverage is limited to 20 visits per benefit period.*	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Pulmonary rehabilitation *office and outpatient hospital Coverage is limited to 20 visits per benefit period.*	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Cardiac rehabilitation *office and outpatient hospital Coverage is limited to 36 visits per benefit period.*	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Dialysis/Hemodialysis *office and outpatient hospital*	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Chemo/Radiation Therapy *office and outpatient hospital*	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Skilled Nursing Care (facility) *Coverage for Skilled Nursing and Inpatient Rehabilitation facility (includes services in an outpatient day rehabilitation program) is limited to 100 days combined per benefit period.*	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Inpatient Hospice	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Durable Medical Equipment	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	0% coinsurance after deductible is met	20% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Pharmacy Deductible	Combined with In-Network medical deductible	Combined with Out-of-Network medical deductible
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with Out-of-Network medical out-of-pocket limit
Prescription Drug Coverage **Network:** ***Base Network*** **Drug List:** ***National*** *Drugs not included on the drug list will not be covered.*		
Day Supply Limits: **Retail Pharmacy** *30 day supply (cost shares noted below)* **Rx Maintenance 90 Pharmacy** *90 day supply (after 2 courtesy 30-day fills you will be required to purchase maintenance medications in 90-day fills at a M90 pharmacy or home delivery).* **Home Delivery Pharmacy** *90 day supply (maximum cost shares noted below). Maintenance medications are available through our home delivery pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service.* **Specialty Pharmacy** *30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy. Drug cost share assistance programs may be available for certain specialty drugs.*		
Tier 1 - Typically Generic	0% coinsurance after deductible is met (retail and home delivery)	Not applicable
Tier 2 - Typically Preferred Brand	0% coinsurance after deductible is met (retail and home delivery)	Not applicable
Tier 3 - Typically Non-Preferred Brand	0% coinsurance after deductible is met (retail and home delivery)	Not applicable
Specialty Medications (brand and generic)	0% coinsurance after deductible is met (retail and home delivery)	No coverage

Notes:

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

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

Questions: (833) 639-1634 or visit us at www.anthem.com

Your summary of benefits

Anthem

PPO PLAN

CEBCO

Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Blue Access CEBCO Miami County PPO Plan 1D/1D Med/Rx

Your Network: Blue Access **Effective Date: 1/1/2025**

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	No charge medical deductible does not apply
Mental Health & Substance Use Disorder Services	No charge medical deductible does not apply
Specialist care	$40 copay per visit medical deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible	$500 person / $1,000 family	$1,000 person / $2,000 family
Overall Out-of-Pocket Limit	$2,500 person / $5,000 family	$5,000 person / $10,000 family
EMBEDDED: The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per person deductible or per person out-of-pocket limit. All medical deductibles, copayments and coinsurance apply to the out-of-pocket limit(s). In-Network and Out-of-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.		
Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP).*		
Primary Care (PCP) and Mental Health and Substance Use Disorder Services *virtual and office*	$20 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Specialist Care *virtual and office*	$40 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Other Practitioner Visits		
Maternity Doctor services (prenatal/postnatal care and delivery)	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Emergency and Urgent Care		
Urgent Care *includes doctor services. Additional charges may apply depending on the care provided.*	$50 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Emergency Room Facility Services *Your copay will be waived if admitted.*	$250 copay per visit and 0% coinsurance medical deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services	0% coinsurance medical deductible does not apply	Covered as In-Network
Ambulance	20% coinsurance after medical deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder Services at a Facility		
Facility Fees	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Doctor Services	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Physician and other services *including surgeon fees*		
Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)		
Facility Fees	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Human Organ and Tissue Transplants *Cornea transplants are treated the same as any other illness and subject to the medical benefits.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Physician and other services *including surgeon fees*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Home Health Care *Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.* *Coverage for occupational therapy is limited to 30 visits per benefit period, physical therapy is limited to 30 visits per benefit period and speech therapy is limited to 20 visits per benefit period.*		
Office	$40 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Manipulation Therapy *Coverage is limited to 12 visits per benefit period.*		
Office	$40 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Pulmonary rehabilitation *Coverage is limited to 20 visits per benefit period.*		
Office	$40 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Cardiac rehabilitation *Coverage is limited to 36 visits per benefit period.*		
Office	$40 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Dialysis/Hemodialysis		
Office	$40 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Chemo/Radiation Therapy		
Office	$40 copay per visit medical deductible does not apply‡	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Skilled Nursing Care (facility) *Coverage for Skilled Nursing and Inpatient Rehabilitation facility (includes services in an outpatient day rehabilitation program) is limited to 90 days combined per benefit period.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Inpatient Hospice	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Durable Medical Equipment	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

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

Notes:

- Dependent Age Limit: to the end of the month in which the child attains age 26.
- Members are encouraged to always obtain prior approval when using Out-of-Network Providers. Precertification will help the member know if the services are considered not medically necessary.
- No charge means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing an Out-of-Network Provider, the member is responsible for any balance due after the plan payment.
- The Primary Care Physician and Specialist office visit copay applies to both office and facility based office visits for evaluation and management services only.
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- The limits for physical, occupational, and speech therapy, if any apply to this plan, will not apply if you get care as part of the Mental Health and Substance Use Disorder benefit.
- ‡ You will pay the PCP's office visit copay when services are provided in their office.
- If you have received Urgent Care at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under “Outpatient Facility Services” which is generally coinsurance or coinsurance after your deductible is met.
- Ohio's House Bill 388 and the Federal No Surprises Act establish patient protections including from Out-of-Network Providers' surprise bills ("balance billing") for Emergency Care and other specified items or services. We will comply with these new state and federal requirements including how we process claims from certain Out-of-Network Providers.
- The representations of benefits in this document are subject to Ohio Department of Insurance (ODI) approval and are subject to change.

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

Questions: (833) 639-1634 or visit us at www.anthem.com

PREVENTIVE RX DRUG LIST

(For High Deductible Plan Enrollees Only)

QUESTIONS? Contact Anthem at 833.930.1772

PreventiveRx℠ Drug List:
Enhanced Plan (National Drug List)

PreventiveRx covers drugs that may keep you healthy because they may prevent illness and other health conditions. You can get the products on this list at low or no cost to you depending on your benefit.

This list includes only prescription products. Brand-name drugs are listed with a first capital letter. Non-brand drugs (generics) are in lowercase letters.

Brand-name drugs that have a generic equivalent available are not covered under this Preventive Rx benefit.

Not all drugs on this list may be covered by your plan. Some drugs, such as those used for cosmetic purposes, may be excluded from your benefits. Please refer to your Certificate or Evidence of Coverage for coverage limitations and exclusions.

ASTHMA
Advair HFA
albuterol sulfate hfa
albuterol sulfate nebulization soln, syrup, tabs
Arnuity Ellipta
Breo Ellipta
budesonide/formoterol aerosol
budesonide inhalation suspension
cromolyn sodium nebulization soln
elixophyllin
Flovent Diskus
Flovent HFA
fluticasone salmeterol blistr powder for inhalation
levalbuterol nebulization soln
levalbuterol tartrate HFA
metaproterenol sulfate syrup, tabs
montelukast
Perforomist
ProAir HFA
ProAir RespiClick
QVAR
Serevent Diskus
Spiriva Respimat
Symbicort
terbutaline sulfate injection, tabs
Theo- 24
theochron
theophylline, ER, CR
Ventolin HFA
wixela inhub
zafirlukast

BLOOD CLOTS
Brilinta
Eliquis
heparin
jantoven
warfarin
Xarelto

DIABETES
Diabetic supplies including blood glucose meters, test strips and lancets require a prescription to be covered by this plan. Only blood glucose meters & blood glucose test strips by Lifescan & Roche will be covered by this benefit.
acarbose
ActoPlusMet XR
alogliptin
alogliptin/metformin
alogliptin/pioglitazone
chlorpropamide
Farxiga
glimepiride
glipizide
glipizide er/xl
glipizide with metformin hcl
glyburide
glyburide with metformin hcl
glyburide, micronized
Humalog
Humalog KwikPen
Humulin
Humulin KwikPen
Insulin Lispro
Insulin Lispro Junior
Insulin Lispro Pen
Insulin Lispro Protamin
Janumet
Janumet XR
Januvia
Jardiance
Lantus
Lantus Solostar
Levemir
Levemir Flexpen
Levemir FlexTouch
metformin hcl
metformin hcl er (Generic for Glucophage XR)
miglitol
nateglinide
Ozempic
pioglitazone
pioglitazone- glimepiride
pioglitazone- metformin
repaglinide
repaglinide- metformin
Rybelsus
Symlin
Synjardy
Synjardy XR
tolazamide
tolbutamide
Toujeo
Tresiba
Tresiba Flextouch
Trulicity
Victoza
Xigduo XR

HEART HEALTH AND HIGH BLOOD PRESSURE
acebutolol hcl
acetazolamide
afeditab cr
amiloride hcl
amiloride/ hctz
amlodipine besylate
amlodipine/ benazepril
amlodipine/ olmesartan
amlodipine/ valsartan
amlodipine/ valsartan/ hctz
atenolol
atenolol/ chlorthalidone
benazepril hcl
benazepril hcl/ hctz
betaxolol hcl
Bidil
bisoprolol fumarate
bisoprolol fumarate/ hctz
bumetanide
candesartan
candesartan/ hctz
captopril
captopril/ hctz
cartia XT
carvedilol
carvedilol er
chlorothiazide
chlorthalidone
clonidine tabs, patches
digitek
digox
digoxin
Dilatrate SR
diltiazem cd
diltiazem hcl
diltiazem hcl er
doxazosin mesylate
enalapril maleate
enalapril/ hctz
eplerenone
eprosartan
ethacrynic acid tabs
ezetimibe
ezetimibe/simvastatin
felodipine er
fosinopril sodium
fosinopril/ hctz
furosemide
guanfacine hcl
hydralazine hcl
hydrochlorothiazide
indapamide
irbesartan
irbesartan/ hctz

PreventiveRx℠ Drug List:
Enhanced Plan (National Drug List)

Anthem

isosorbide dinitrate
isosorbide dinitrate er
isosorbide mononitrate
isosorbide mononitrate er
isradipine
labetalol hcl
lisinopril
lisinopril/ hctz
losartan
losartan/ hctz
matzim la
methazolamide
methyclothiazide
methyldopa
methyldopa/ hctz
metolazone
metoprolol succinate er
metoprolol tartrate
metoprolol tart/ hctz
minitran
minoxidil
moexipril hcl
moexipril/ hctz
nadolol
nadolol/ bendroflumethiazide
nicardipine hcl
nifedipine
nifedipine er
nimodipine
nisoldipine er
Nitro-Dur 0.3, 0.8mg/ hr
nitroglycerin
nitroglycerin 400 mcg spray
nitroglycerin er
nitroglycerin lingual
nitroglycerin sl tabs
olmesartan
olmesartan/ hctz
olmesartan/amlodipine/ hctz
perindopril
pindolol
prazosin hcl
propranolol hcl
propranolol hcl er
propranolol/ hctz
quinapril hcl
quinapril/ hctz
ramipril
ranolazine er
sorine
sotalol hcl
sotalol hcl af
spironolactone
spironolactone/ hctz
taztia xt
telmisartan
telmisartan/ amlodipine
telmisartan/ hctz
terazosin hcl
tiadylt
timolol maleate tablet
torsemide
trandolapril
trandolapril/ verapamil
triamterene/ hctz
valsartan
valsartan/ hctz
verapamil hcl
verapamil hcl er

HEART RATE AND RHYTHM
amiodarone
disopyromide
flecainide
mexiletine
Norpace CR
pacerone
propafenone
propafenone ER
quinadine
quinidine ER, CR

HIGH CHOLESTEROL
atorvastatin
atorvastatin/ amlodipine
cholestyramine
cholestyramine light
colesevelam
colestipol hcl
ezetimibe
ezetimibe-simvastatin
fenofibrate (43, 50, 67, 130, 134, 150, 200 mg capsules & 40, 48, 54, 120, 145, 160mg tablets)
fenofibric acid
fluvastatin
fluvastatin ER
gemfibrozil
lovastatin
niacin ER
pravastatin
prevalite
rosuvastatin
simvastatin

MALARIA
atovaquone/proguanil
chloroquine
mefloquine
primaquine

MENTAL HEALTH
amitriptyline
amoxapine
aripiprazole
aripiprazole ODT
bupropion
bupropion SR
bupropion XL
carbamazepine
carbamazepine ER
chlorpromazine
citalopram
clomipramine
clozapine
clozapine ODT
desipramine
desvenlafaxine ER
Dilantin
divalproex sodium DR, ER
Doxepin
duloxetine
Epitol
escitalopram
ethosuximide
felbamate
fluoxetine tablets 10 mg, 20 mg
fluoxetine capsules, solution
fluoxetine DR
fluphenazine
fluvoxamine
fluvoxamine ER
gabapentin
haloperidol tablets
Imipram
imipramine tablets, capsules
lamotrigine
lamotrigine ER
lamotrigine ODT
levetiracetam
levetiracetam ER
lithium
lithium ER
loxapine
maprotiline
mirtazapine
mirtazapine ODT
molindone
nefazodone
nortriptyline
olanzapine
olanzapine ODT
oxcarbazepine
paliperidone ER
paroxetine
paroxetine ER
perphenazine
phenelzine
phenytoin
phenytoin ER
pregabalin
primidone
prochlorperazine
protriptylin
quetiapine
quetiapine ER
risperidone
risperidone ODT
roweepra
sertraline
subvenite
thioridazine
thiothixene
tiagabine
topiramate
topiramate ER
tranylcypromine
trazodone
trifluoperazine
trimipramine
Trokendi XR
valproic acid
venlafaxine
venlafaxine ER
ziprasidone
zonisamide

OSTEOPOROSIS
alendronate sodium
amabelz
calcitonin- salmon
Climara Pro
Combipatch
dotti
estradiol tab, patch
estradiol/ norethindrone acetate
estropipate
Fosamax Plus D
ibandronate sodium tablets
Jevantique
jinteli
medroxyprogesterone acetate
Menest
norethindrone-ethinyl estradiol
Premarin tablets
Premphase
Prempro
raloxifene
risedronate

STROKE
aspirin- dipyridamole ER
cilostazol
clopidogrel bisulfate
dipyridamole
prasugrel

This list may change without notice which may affect your benefit coverage. To be sure your medication is covered under the PreventiveRx benefit, call the member services number located on your ID card.

A00526ANMENABS Rev. 4/1/2021

CHOOSING A PLAN WISELY

To determine the maximum potential cost of each plan, you must consider all factors including your payroll deductions, out of pocket expenses and, for those enrolled in the high deductible plan, Miami County's HSA contribution. It is also critical that you understand the difference between the high deductible and PPO plans.

EXAMPLE

The graphic below is an illustrative example of how the deductibles and out-of-pocket maximums compare among the two different plans for employee-only coverage. The deductibles and max out of pocket amounts for the two plans are as follow:

	PPO PLAN	HDHP
Annual Deductible	$500	$3,500
Max Out of Pocket (MOOP)	$2,500	$3,500
Co-Insurance	20%	N/A

Example 1

Abigail goes to the emergency room in January for chest pains. The physicians determine that she does not need to be admitted through a series of tests. She has had no claims submitted to insurance so far this year.

She has received $250 toward her HSA account from the County.

The hospital bills Abigail's insurance for $7,441 and the insurance company determines that **$2,432** is the allowable amount per the contract.

		PPO	HDHP
DEDUCTIBLE	Applied	$500	$2,432
	Met	Yes	No
	Remaining	$0	$1,068
PPO CO-INSURANCE *20% of balance after deductible*		$386	N/A
HSA CONTRIBUTION		N/A	$250
EMPLOYEE OUT OF POCKET COST *Deductible + Co-Insurance - HSA*		$886	$2,182
MAX OUT OF POCKET	Applied	$886	$2,432
	Met	No	No
	Remaining	$1,614	$1,068

Example 2

Abigail has a procedure done in May. She had no other claims submitted between her January ER visit and this procedure.

She received a second HSA deposit of $250 in April. Only the PPO deductible has been met. Neither max out of pocket has been reached.

The provider bills Abigail's insurance for $2,836 and the insurance company determines that **$1,245** is the allowable amount per the contract.

		PPO	HDHP
DEDUCTIBLE	Applied	$0	$1,068
	Met	Yes	Yes
	Remaining	$0	$0
PPO CO-INSURANCE *20% of balance after deductible*		$249	N/A
HSA CONTRIBUTION		N/A	$250
EMPLOYEE OUT OF POCKET COST *Deductible + Co-Insurance - HSA*		$249	$818
MAX OUT OF POCKET	Applied	$249	$3,500
	Met	No	Yes
	Remaining	$1,365	$0

It is also important to keep in mind that Abigail would pay $44.15 more per pay (or $1,059.60 annually) to be on the PPO plan. However, she will also receive another $250 HSA deposit from the County in July and another in October.

SYDNEY HEALTH APP

Anthem

County Employee Benefit Consortium of Ohio CEBCO Health & Wellness

The Sydney Health mobile app makes healthcare easier

Access personalized health and wellness information wherever you are

Use Sydney℠ Health to keep track of your health and benefits — all in one place. With a few taps, you can quickly access your plan details, Member Services, virtual care, and wellness resources. Sydney Health stays one step ahead — moving your health forward by building a world of wellness around you.

Find Care

Search for doctors, hospitals, and other healthcare professionals in your plan's network and compare costs. You can filter providers by what is most important to you, such as gender, languages spoken, or location. You'll be matched with the best results based on your personal needs.

My Health Dashboard

Use My Health Dashboard to find news on health topics that interest you, health and wellness tips, and personalized action plans that can help you reach your goals. It also offers a customized experience just for you, such as syncing your fitness tracker and scanning and tracking your meals.

Chat

If you have questions about your benefits or need information, Sydney Health can help you quickly find what you're looking for and connect you to an Anthem representative.

Virtual Care

Connect directly to care from the convenience of home. Assess your symptoms quickly using the Symptom Checker or talk to a doctor via chat or video session.

Community Resources

This resource center helps you connect with organizations offering no-cost and reduced-cost programs to help with challenges such as food, transportation, and child care.

My Health Records

See a full picture of your family's health in one secure place. Use a single profile to view, download, and share information such as health histories and electronic medical records directly from your smartphone or computer.

Download the Sydney Health app today

Use the app anytime to:

- Find care and compare costs.
- See what's covered and check claims.
- View and use digital ID cards.
- Check your plan progress.
- Fill prescriptions.

Scan the QR code to download the Sydney Health app.

You can also set up an account at anthem.com/register to access most of the same features from your computer.

For technical support call: 866-755-2680

In addition to using a telehealth service, you can receive in-person or virtual care from your own doctor or another healthcare professional in your plan's network. If you receive care from a doctor or healthcare professional not in your plan's network, your share of the costs may be higher. You may also receive a bill for any charges not covered by your health plan.

Sydney Health is offered through an arrangement with Carelon Digital Platforms, a separate company offering mobile application services on behalf of your health plan. ©2020-2022 The Virtual Primary Care experience is offered through an arrangement with Hydrogen Health.

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. Copies of Colorado network access plans are available on request from member services or can be obtained by going to anthem.com/co/networkaccess. In Connecticut: Anthem Health Plans, Inc. In Georgia: Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. HMO plans are administered by Anthem Health Plans of New Hampshire, Inc. and underwritten by Matthew Thornton Health Plan, Inc. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI), underwrites or administers PPO and indemnity policies and underwrites the out of network benefits in POS policies offered by Compcare Health Services Insurance Corporation (Compcare) or Wisconsin Collaborative Insurance Corporation (WCIC). Compcare underwrites or administers HMO or POS policies; WCIC underwrites or administers Well Priority HMO or POS policies. Independent licensees of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

Support your health and well-being with the Sydney Health mobile app

For personalized support and health topics that interest you, Sydney℠ Health offers useful health and wellness tips and individualized action plans that can help you reach your goals. You can also find and connect with clinical and well-being programs for a variety of topics, ranging from pregnancy to heart disease.

- **Set goals** - Answer ten questions about your health goals and Sydney Health will personalize your dashboard and show where you may be able to improve.
- **Learn about healthy living** - Find videos and online articles with tips on healthy living, including nutritionist-approved recipes and meal plans.
- **Track nutrition** – Scan food and labels with your smartphone camera for quick logging or use voice commands. Customize your nutrition goals based on your preferences, such as keto.
- **Keep moving** - Stay motivated with support throughout your journey that includes rewards, profile badges, and points to help you stay on track.
- **Personalize your action plan** - Work toward your health goals and make healthy choices that fit your lifestyle. Plans include getting active, eating healthier, losing weight, reducing stress, and sleeping better. You can even sync your wearable fitness device to the app for easy activity tracking.

Check out these features today by downloading the **Sydney Health app** and visiting **My Health Dashboard.**

Download the Sydney Health app

Scan the QR code using the camera on your smartphone.

Download on the App Store

GET IT ON Google Play

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You can sync your wearable device

To start tracking your activity*:

- Log in to Sydney Health.
- Select **My Health Dashboard** and go to **Activity Tracking.**
- Select **Manage Devices/Apps**
  - If syncing an Apple® or Google™ device, use the Sydney Health app to connect and manage.
  - For other wearables, select from the list on the screen and follow the prompts and instructions.

Earn rewards by making healthier choices

Your healthy choices deserve recognition. Find support on the Sydney Health app where you can access your benefit information and wellness rewards all in one place. Log in today to see if you're eligible to earn rewards by participating in activities such as tracking your steps, and completing a wellness exam, and reading educational articles.

We're here to help

If you have questions, Sydney Health can help you quickly find what you're looking for and connect you to an Anthem representative.

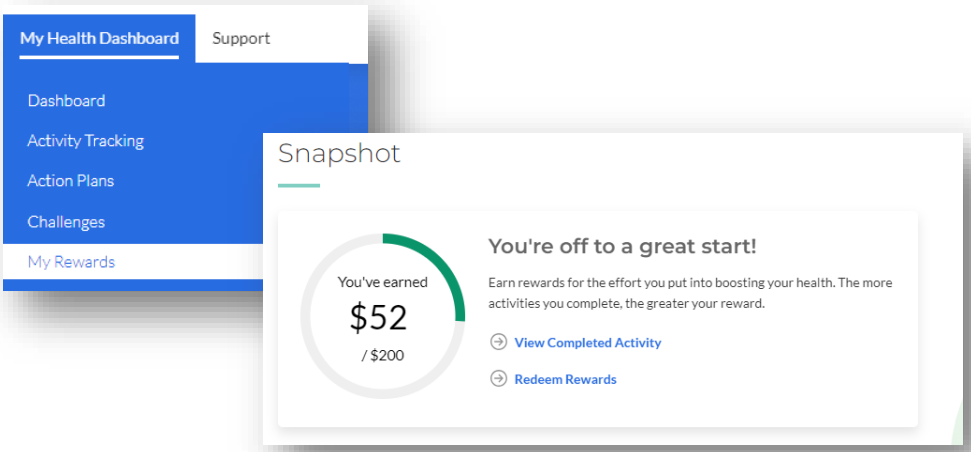
* The experience may vary for older devices.

WELLNESS AT MIAMI COUNTY

EARN MONEY BY COMPLETING THESE HEALTHY ACTIVITIES!

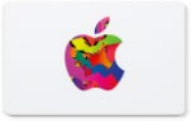
Employees and their covered spouses can each earn up to $200 for completing a number of rewardable activities between August 15, 2024 and August 14, 2025.

All activities and rewards are tracked and redeemed through the Sydney app or online at **Anthem.com** > MY HEALTH DASHBOARD > MY REWARDS.



Redeem for Gift Cards

Amazon.com eGift Card


Apple Gift Card

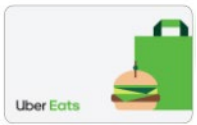
GAP Options eGiftCard


Home Depot eGift

Mastercard® Virtual

T.J.Maxx | Marshalls |

Target eGiftCard



Uber eGift

$50

Wellness Exam
Log Daily Activity
($2/50k Steps, up to $50)

$25

Cholesterol Test
Colorectal Cancer Screening
Complete a Team Challenge Goal
ConditionCare Program
Diabetic A1c Lab Test
Health Profile
Login to Sydney App
Mammogram
Prostate Exam
Skin Cancer Screening

SMARTSHOPPER

Save money on health tests and procedures

SmartShopper helps you find the best value for high-quality care

We understand that medical procedures can be costly and can sometimes seem unpredictable. In fact, the same test or procedure can vary by hundreds or even thousands of dollars, depending on where you go. SmartShopper makes it easy to compare cost information about common health procedures. You can even earn cash* rewards when you choose a health care provider known for high-quality outcomes.

Shop on your own or with a Personal Assistant

It's easy to use SmartShopper. Shop online at **smartshopper.com** or call the SmartShopper Personal Assistant Team. Your Personal Assistant will help you understand your options and schedule your appointment. You can reach a Personal Assistant by calling **1-866-285-7078** Monday to Thursday, 8 a.m. to 8 p.m. Eastern and Friday 8 a.m. to 6 p.m. Eastern.

SmartShopper is easy to use

1. When your health care provider suggests a test or procedure, visit **smartshopper.com** or call the SmartShopper Personal Assistant Team at **1-866-285-7078**.
2. Choose where you would like to have your test or procedure. All of the SmartShopper options are in your plan's network.
3. After Anthem pays your claim, SmartShopper will mail you a reward check. Your check should arrive in about six weeks.

We are happy to offer you SmartShopper as part of your Anthem benefit plan. It's one more way that we can help you to save money and receive high-quality health care. To sign up, go to **smartshopper.com** or call the Personal Assistant Team at **1-866-285-7078,** Monday to Thursday, 8 a.m. to 8 p.m. Eastern and Friday 8 a.m. to 6 p.m. Eastern.

Earn cash rewards for choosing health care providers known for high-quality, lower-cost care.

Sample procedures and rewards

Test or procedure	Reward up to:
ACL repair by arthroscopy	$250
Colonoscopy	$250
Mammogram	$50
Ultrasound	$50
Physical therapy	$150

For a full list of procedures and rewards, call the Personal Assistant team at **1-866-285-7078** or visit **smartshopper.com**.

Anthem. SmartShopper® County Employee Benefit Consortium of Ohio CEBCO Health & Wellness

* Reward payments may be taxable.

The SmartShopper program is provided by Sapphire Digital an independent company. Incentives available for select procedures only. Payments are a taxable form of income. Rewards may be delivered by check or an alternative form of payment. Members with coverage under Medicaid or Medicare are not eligible to receive incentive rewards under the SmartShopper program. Rewards are for select procedures only and reward payments may be taxable.

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SWORD: A BETTER WAY TO FEEL BETTER.

Anthem LiveHealth Online Healthy Back & Joints sword CEBCO Health & Wellness

Free for you

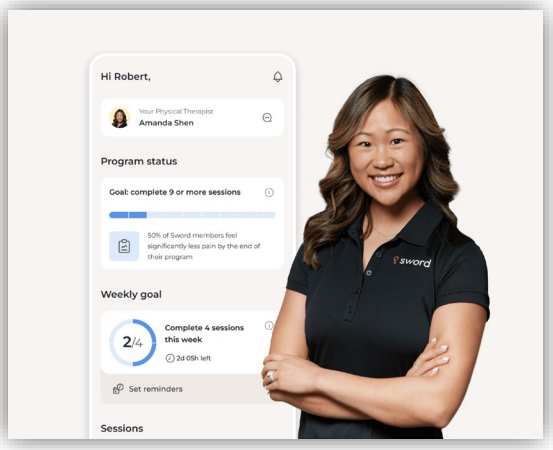
No cost to employees and their family members who are enrolled in one of Miami County's health insurance plans.

Personalized programs

Every Sword program is tailored to your needs and adjusts as you progress.

Anytime, anywhere

The care you need, from the comfort of home, or anywhere else that works for you.




Occasional pain & stiffness

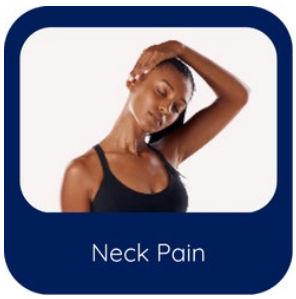

Low back pain


Joint Pain


Menopause Symptoms


Women's bladder or bowel issues

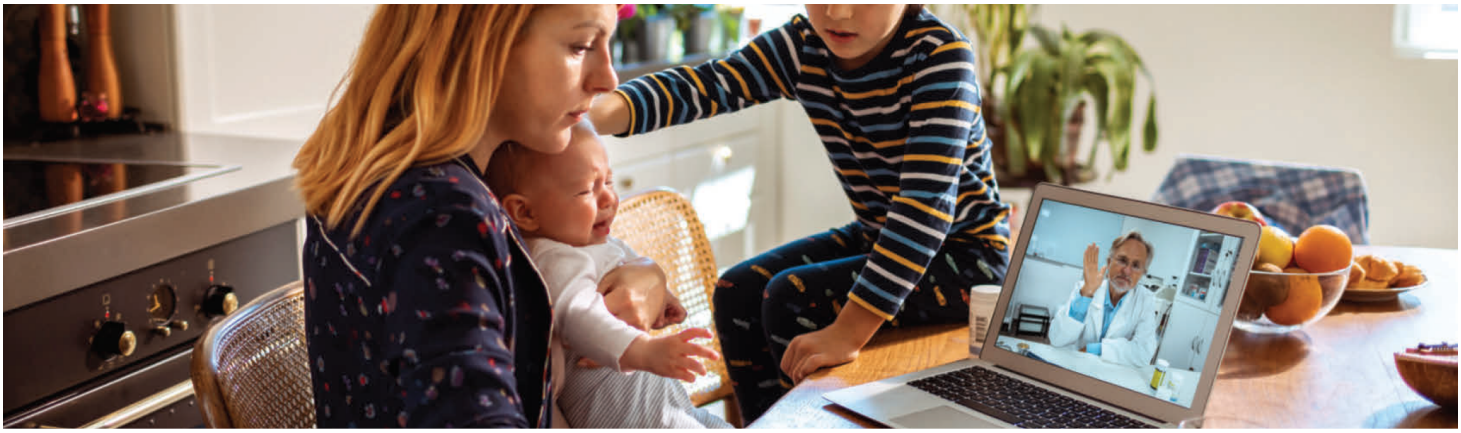

Shoulder Pain


Neck Pain

Download the app and start today.

Google Play App Store

LIVEHEALTH ONLINE: SEE A DOCTOR 24/7



Connect with a doctor anytime, anywhere with LiveHealth Online

When you're not feeling well, you have access to virtual care visits using LiveHealth Online. Whether you have a cold, you're feeling anxious, or need help managing your medication, you can have face-to-face visits with a board-certified doctor, psychiatrist, or licensed therapist from your smartphone, tablet, or computer.

Medical doctors are available 24/7 – no appointment needed.[1]

Doctors can assess symptoms, provide a treatment plan, and prescribe or refill medications.[2] Care is available for health issues such as cold and flu symptoms, allergies, and sinus infections.

Visit a licensed therapist in four days or less.[3]

For help with mental health concerns such as anxiety, stress, and grief, you can connect to a licensed therapist or psychologist in four days or less and within two weeks with a psychiatrist.[4,5]

What's the cost of a LiveHealth Online visit?

PPO plans are covered in full, H.S.A. plans pay:

- $55 per visit with a medical doctor
- $95 per visit with a dermatologist
- $80 per visit with a licensed therapist
- $95 per visit with a psychologist
- $175 for an initial evaluation by a psychiatrist and $75 for a follow-up visit

Start using LiveHealth Online.

To register, go to livehealthonline.com or download the free app. For a medical visit, log on, choose a doctor, and your visit will begin in minutes. For mental health visits, choose from the available dates to schedule your appointment. LiveHealth Online is secure and confidential.[6]

Sign up for LiveHealth Online today and be ready when you need it.

Go to livehealthonline.com or download the free mobile app from the App Store® or Google Play™.

Anthem

County Employee Benefit Consortium of Ohio CEBCO Health & Wellness

1 Appointments may be needed for certain specialists.
2 Prescription availability is defined by physician judgment.
3 Appointments subject to availability of a therapist. Online counseling is not appropriate for all kinds of problems. If someone is in crisis or has suicidal thoughts, it's important that they seek help immediately by calling 800-784-2433 (National Suicide Prevention Lifeline) or 911. LiveHealth Online does not offer emergency services.
4 Prescriptions determined to be a "controlled substance" (as defined by the Controlled Substances Act under federal law) cannot be prescribed using LiveHealth Online.
5 Psychiatrists on LiveHealth Online will not offer counseling or talk therapy.
6 LiveHealth Online is a HIPAA-compliant confidential video service.

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SKIP THE PHARMACY WITH HOME DELIVERY

Skip the pharmacy with home delivery

Anthem.

Save time and effort filling your regular prescriptions

Set up home delivery through CarelonRx Mail for the prescriptions you take long-term for conditions like high blood pressure, diabetes, heart disease, or asthma. You'll receive your medications at your door and enjoy the convenience of not having to visit the pharmacy.

With home delivery, you can count on:

Convenience. Medications are delivered directly to your home or any location you choose.

- Manage your prescriptions with the Sydney[SM] Health app or at **anthem.com**.
- Expect first-time home delivery orders to take about two weeks and refills to take 3 to 5 days.
- Set up reminders and automatic refills, too.

Safety. All orders are checked by a licensed pharmacist before they ship. Discreet packaging is:

- Tamperproof
- Weatherproof
- Temperature controlled, if needed

Peace of mind. You're less likely to miss a dose and more likely to stay on track with the treatment your doctor prescribed when you switch to home delivery.* Trained pharmacists can also answer your questions and help you 24/7.

Hassle-free service. CarelonRx Mail will contact your doctor to order a new, 90-day prescription if you need one. If a medication preapproval is needed, the home delivery team will reach out to you for consent before shipping your medication.

Savings. Many medications cost less when you fill a 90-day supply instead of three 30-day supplies. Shipping is always free.

Start home delivery now with these steps

1. Visit the *Pharmacy* page on **anthem.com**, choose the *Pharmacy* tab on the Sydney Health app, or scan the QR code with your phone's camera. Register your member account if you haven't already.
2. Choose **Request a New Prescription**.
3. Type in the prescription you'd like delivered.
4. Under the name and cost of your prescription, select **Request a New Prescription**.
5. Fill in any blank fields, such as shipping address, payment method, and prescriber.
6. First-time requestors will need to select **Continue to Medical Profile**.
7. Verify any allergies or health conditions, then select **Continue to Submit Order**.

We're here to help

Call CarelonRx Mail at **833-236-6196** or use the live chat feature on Sydney Health or **anthem.com**.

*National Library of Medicine, National Center for Biotechnology website: A Retrospective Database Study Comparing Diabetes-Related Medication Adherence and Health Outcomes for Mail-Order Versus Community Pharmacy (accessed September 2022): ncbi.nlm.nih.gov/pubmed/[illegible].

Sydney Health is offered through an arrangement with Carelon Digital Platforms, a separate company offering mobile application services on behalf of your health plan. ©2020-2022

CarelonRx is an independent company providing pharmacy benefit management services on behalf of your health plan.

26

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LARK: DIABETES PREVENTION

A program focused on helping you improve your health

Introducing digital diabetes prevention coaching

Roughly 88 million Americans are living with prediabetes but 84% aren't even aware they have it.[1] Prediabetes often doesn't cause symptoms, but it does increase the risk of developing type 2 diabetes, heart disease, and stroke. That's why Anthem has partnered with Lark to offer a diabetes prevention program that can help you determine if you're at risk for prediabetes and if needed, take steps to address it.

This program can help you:

- Lose weight
- Eat healthier
- Increase activity
- Sleep better
- Manage stress

Better health is within your reach

You can participate in this program at no extra cost as part of your health plan. Track your progress, check in with your coach, and learn more about prediabetes right in Lark's free mobile app. This program is flexible, convenient, and follows guidelines from the Centers for Disease Control and Prevention (CDC) to help you make small changes that can improve your health and decrease your risk over time.

Anthem. lark County Employee Benefit Consortium of Ohio CEBCO Health & Wellness

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Weight loss with Lark

Losing weight can make a big difference in lowering your risk for type 2 diabetes. Lark members lose an average of 4.2% of their body weight in 12 months on the diabetes prevention program.[2] As part of the program, you receive a wireless scale at no extra cost to help you track your weight loss progress. Your scale also syncs with the Lark app so you can share updates with your coach.

24/7 coaching support

Losing weight and making lifestyle changes can feel intimidating even if you know it can lead to better health. Your coach can help you stay motivated. Send your coach a message anytime from anywhere and receive an immediate response and extra support when you need it most. During the course of the program, your coach will:

- Be available 24/7 through the Lark mobile app to provide personalized coaching.
- Customize your program based on your food preferences and lifestyle.
- Provide educational information on prediabetes and preventing type 2 diabetes.
- Help you learn about how stress affects your health and how to cope with it.

Learn if you are at risk for prediabetes. Go to lark.com/anthem and take a quick one-minute survey to see if you could benefit from Lark's diabetes prevention program.

You are in control of your health. Prevent diabetes and start improving your overall health and well-being today.

1 Centers for Disease Control and Prevention website: *Prediabetes – Your Chance to Prevent Type 2 Diabetes* (accessed October 2020): cdc.gov.

2 Lark internal data

Diabetes Prevention Program is provided by Lark, an independent company.

CEBCO DIABETIC SUPPLY BENEFIT

County Employee Benefit Consortium of Ohio
CEBCO
Health & Wellness

Coverage for diabetic supplies for Durable Medical Equipment (DME) to control diabetes can be difficult to navigate. Some items are covered through prescription benefits while others are covered through medical benefits. To access benefits for diabetic supplies, you must have a prescription. The items listed below are covered at the levels indicated with a prescription through your benefit with **Anthem Rx** when purchased through a pharmacy.

NO EXPENSE TO YOU	COINSURANCE RESPONSIBILITY	DEDUCTIBLE & COINSURANCE
Lancets	Meters	Infusion Sets
Test Strips	Alcohol Swabs	Reservoirs
Needles	Freestyle Libre	Insulin Pump
Syringes	Freestyle Libre 2	Tubing
Ketone Strips	Dexcom G6	Pump Supplies
	Omnipod	
	Omnipod Dash	

These are considered supplies to equip Durable Medical Equipment (DME).

CEBCO's benefits for diabetic supplies follow accepted insurance guidelines

PROTECTING YOUR PRIVACY

Protecting your privacy

How we keep your information safe and secure

As a member, you have the right to expect us to protect your personal health information. We take this responsibility very seriously, following all state and federal laws, as well as our own policies.

You also have certain rights and responsibilities when receiving your healthcare. To understand how we protect your privacy, your rights and responsibilities when receiving healthcare, and your rights under the Women's Health and Cancer Rights Act, go to **anthem.com/privacy**. For a printed copy, please contact your Benefits Administrator or Human Resources representative.

How we help manage your care

To see if your health benefits will cover a treatment, procedure, hospital stay, or medicine, we use a process called utilization management (UM). Our UM team is made up of doctors and pharmacists who want to be sure you receive the best treatments for certain health conditions. They review the information your doctor sends us before, during, or after your treatment. We also use case managers. They're licensed healthcare professionals who work with you and your doctor to help you manage your health conditions. They also help you better understand your health benefits..

For additional information about how we help manage your care, go to **anthem.com/memberrights**. To request a printed copy, please contact your Benefits Administrator or Human Resources representative.

Special enrollment rights

Open enrollment usually happens once a year. That's the time you can choose a plan, enroll in it, or make changes to it. If you choose not to enroll, there are special cases when you're allowed to enroll during other times of the year.

- **If you had another health plan that was canceled.** If you, your dependents, or your spouse are no longer eligible for benefits with another health plan (or if the employer stops contributing to that health plan), you may be able to enroll with us. You must enroll within 31 days after the other health plan ends (or after the employer stops paying for the plan). For example: You and your family are enrolled through your spouse's health plan at work. Your spouse's employer stops paying for health coverage. In this case, you and your spouse, as well as other dependents, may be able to enroll in one of our plans.
- **If you have a new dependent.** You gain new dependents from a life event, such as marriage, birth, adoption, or if you have custody of a minor and an adoption is pending. You must enroll within 31 days after the event. For example: If you marry, your new spouse and any new children may be able to enroll in a plan.
- **If your eligibility for Medicaid or SCHIP changes.** You have a special period of 60 days to enroll after:
  - You (or your eligible dependents) lose Medicaid or the State Children's Health Insurance Program (SCHIP) benefits because you're no longer eligible..
  - You (or eligible dependents) become eligible to receive help from Medicaid or SCHIP for paying part of the cost of a health plan with us.

It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. By calling Member Services, our members can get free in-language support, and free aids and services if you have a disability. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. 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 in any of these areas, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279, or directly to 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. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**.

For full details, read your plan document, which has all the details about your plan. You can it find on **anthem.com**.

HEALTH SAVINGS ACCOUNT

www.parknationalbank.com 1.888.474.7275

IMPORTANT: This account can only be paired with the high-deductible health plan. If you are enrolled in the PPO plan, you are not eligible for this account.

A Health Savings Account (HSA) helps you pay for out-of-pocket medical expenses and save for future costs. The funds can be spent on a variety of things, including trips to the chiropractor, purchasing eyeglasses, and paying for your prescription medications - giving you the flexibility on how and where you spend your money. These accounts are tax-advantaged and the balances roll over from year to year.

MIAMI COUNTY'S CONTRIBUTION TO YOUR HSA ACCOUNT

Miami County's quarterly contributions will be made in equal installments on the 10th (or the first business day following) of January, April, July, and October.

Miami County contributes money into a health savings account for employees enrolled in the high-deductible health plan. The Board has elected to continue to provide the following contribution amounts for the 2025 Plan Year.

To be eligible for an HSA contribution, you must:

- Be in an active payroll status with Miami County
- Be enrolled a high-deductible health plan through Miami County; and
- Have an HSA account set up with Park National Bank.

MAXIMUM CONTRIBUTION AMOUNTS

The County contributions and any individual contributions you choose to make cannot exceed the limits set forth by the IRS. The limits, along with the amount you can also contribute, for 2025 are listed below.

ENROLLMENT LEVEL	IRS LIMIT	COUNTY CONTRIBUTION	MAX EMPLOYEE CONTRIBUTION
Individual	$4,300	$1,000	$3,300
Family	$8,550	$2,000	$6,550
Catch-Up Contributions *(Age 55+)*	$1,000	-	$1,000

SETTING UP YOUR ACCOUNT

Miami County partners with Park National Bank for HSA accounts. Simply visit your local Park National Bank to set up your account. If you are unable to go to a location during regular business hours, contact your HR team for assistance.

Troy
1314 W. Main Street
937.339.6626

Piqua – West
1603 Covington Ave.
937.778.4617

Piqua – Downtown
215 N. Wayne Street
937.615.1042

Tipp City
1176 W. Main Street
937.667.4888

IMPORTANT NOTE REGARDING MEDICARE AND HSA PLANS

If your spouse is covered by Medicare and Miami County's plan, your annual maximum contribution will equal that of the individual instead of family because Medicare enrollees are not permitted to contribute to an HSA plan. Additionally, per IRS regulations, individuals must cease HSA contributions six-months prior to their Medicare effective date.

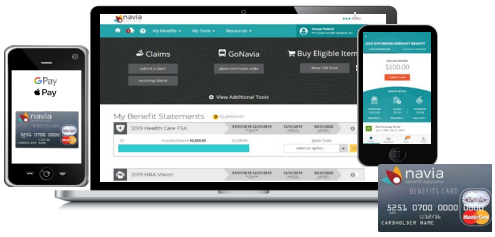
FLEXIBLE SPENDING ACCOUNTS

www.naviabenefits.com 1.800.247.4695 Account Code: MUO

With a Flexible Spending Account (FSA), you can save money pretax for healthcare expenses, including medical, dental, and vision, that are either not covered or only partially covered by your insurance plan. These expenses can be for you, your spouse, or child(ren) even if they are not enrolled in a health insurance plan with you.

Claims can be submitted between January 1, 2025 and March 15, 2026. You will lose any amounts remaining after the run-out period so it is important to plan your contributions carefully.

ACCESSING YOUR ACCOUNT



Download the MyNavia mobile app by searching for "Navia Benefits" in the Google Play or Apple App Store. If you have not previously created an online account, you can do so within the app by clicking on "Register Online". Use the account code **MUO** when prompted.

You can also access your account online at https://www.naviabenefits.com

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

Dependent care expenses can be paid for from this FSA account, including daycare or after-school care for children under 13 years of age, an elderly person or a person with disabilities as long as they are claimed as a dependent on your tax return. Unused funds are forfeited after a run-out period following the end of the plan year.

Your contributions to the Dependent Care account cannot exceed the limit of $5,000 set forth by the IRS. Unlike a Healthcare FSA, a Dependent Care FSA is not pre-funded. This means your total annual election is not immediately available at the beginning of the plan year.

In addition to the standard Life Event list, you can also make the following mid-year changes to your Dependent Care FSA if you experience any of the following events:

- A change in your day care costs, such as a rate decrease or increase, or receiving free day care.
- A change in your need for day care (e.g., your spouse loses employment or has a change in work schedule).
- Your dependent ceases to satisfy the eligibility requirements.

HEALTHCARE FLEXIBLE SPENDING ACCOUNT

The Healthcare Flexible Spending Account cannot be utilized in conjunction with a high-deductible health plan.

A Healthcare FSA is a personal expense account that allows you to set aside a portion of your salary pre-tax to pay for qualified medical expenses.

Healthcare FSAs can be used to pay for eligible expenses, including medical, prescription drugs, dental, and vision. Copays, co-insurance, and deductibles can be paid from these accounts. Healthcare FSA account balances can carry-over up to $660 annually for 2025 enrollments. This option is limited only to individuals not enrolled in a High-Deductible Health Plan or contributing to an HSA account.

Your contributions to the Health Care account cannot exceed the annual limit set by the IRS, which for 2025 is $3,300.

Visit Miami County's HR page for a listing of eligible expenses under a Healthcare Flexible Spending Account.

VISION PLANS

www.vsp.com 1.800.877.7195

Refer to plan document in UKG for out of network coverages.

	PLAN A (005)		PLAN B (006)	
VISION EXAM	$10 Copay			
CONTACT LENS EXAM	Covered in full after copay, **Receive 15% off contact lens exam services**; Copay will never exceed $60			
FREQUENCY	Exam, Lenses, Frame: Every other calendar year		Exam & Lenses: Every calendar year Frames: Every other calendar year	
CONTACT LENS COVERAGE				
Necessary Contact Lenses	Covered in full after copay up to allowance			
Elective Contact Lenses	$130 Allowance			
FRAME COVERAGE	$15 Copay; $200 Frame allowance; ***+20% off any amount above the allowance***			
PRESCRIPTION LENSES	Single Vision, Lined Bifocal, Lined Trifocal, Lenticular: Covered in full after copay up to allowance			
LENS ENHANCEMENTS	**SINGLE VISION**	**MULTIFOCAL**	**SINGLE VISION**	**MULTIFOCAL**
Standard Anti-Glare Coating	$37 after copay	$37 after copay	$37 after copay	$37 after copay
All Other Anti-Glare Coating	$51-$75 after copay	$51-$75 after copay	$51-$75 after copay	$51-$75 after copay
Impact-Resistant for Children	Covered in full after copay		Covered in full after copay	
Impact-Resistant for Adults	$23 after copay	$28 after copay	$23 after copay	$28 after copay
Standard Progressives	N/A	Covered in full after copay	N/A	Covered in full after copay
Premium & Custom Progressives	N/A	Covered in full after copay	N/A	Covered in full after copay
Tints/Light-Reactive Lenses	$70 after copay		$70 after copay	
Scratch-Resistant Coating	$15 after copay		$15 after copay	
LIGHTCARE	Covered in full after copay *Allows you to use frame allowance toward non-Rx blue light filtering glasses/sunglasses from the doctor's frame board or Eyeconic. Exhausts both lens & frame eligibility.*			

QUICK TIPS

Find a provider, order online, or find out how much your glasses will cost by using the cost estimator available on your VSP account at VSP.com

	PLAN A (005)	PLAN B (006)
Rate per Check	**You Pay**	**You Pay**
Employee	$4.20	$5.78
Employee + 1	$8.42	$11.58
Family	$12.75	$17.57

DENTAL PLANS

Principal

www.principal.com 1.800.247.4695

CHOICE POINT NETWORK	PLAN A (LOW)	PLAN B (HIGH)
BASIC & MAJOR DEDUCTIBLE	$50/Single $150/Family	$50/Single $150/Family
ANNUAL MAXIMUM BENEFIT	$1,000 per Person	$1,500 per Person
PREVENTATIVE SERVICES Exams, cleanings, x-rays, fluoride treatment for children, ER treatment, sealants for children, space maintainers	Covered in Full	Covered in Full
BASIC SERVICES Fillings, simple extractions, root canal therapy, oral surgery, repairs and recommendations, periodontal treatment	80% after Deductible	80% after Deductible
MAJOR SERVICES	Not Covered	50% after Deductible
ORTHODONTIC SERVICES	Not Covered	50% up to $1,000

	PLAN A (Low)	PLAN B (High)
Rate per Check	**You Pay**	**You Pay**
Employee	$13.80	$21.45
Employee + Child(ren)	$28.60	$44.84
Employee + Spouse	$25.59	$40.57
Family	$47.20	$74.32

PRINCIPAL DENTAL ROLLOVER BENEFIT

QUICK TIPS

Simply by getting your preventive dental appointment done annually, you could be eligible to roll a portion of your unused, annual maximum over to the next year!

Members who incur 50% or less of their annual maximum benefit will be eligible to roll over 25% of their annual maximum benefit to the following year, up to 100% of the annual maximum.

Following are illustrative examples of how this benefit could work for each plan level. You can see that in year 2, where benefits paid were more than the yearly claim limit—which is 50% of the maximum—there was no rollover. And in year 4, where there were no claims at all, your accumulated amount went back down to zero. That is why it pays to visit the dentist regularly for preventive care.

ROLLOVER EXAMPLE FOR LOW PLAN ($1,000 ANNUAL MAXIMUM)				
Year	**Annual Max + Rollover**	**Benefits Paid**	**Eligible**	**Rollover *25% of Max***
1	$1,000	$450	Yes	$250
2	$1,250	$850	No	$0
3	$1,250	$450	Yes	$250
4	$1,500	$0	No	$0
5	$1,000	$450	Yes	$250

ROLLOVER EXAMPLE FOR HIGH PLAN ($1,500 ANNUAL MAXIMUM)				
Year	**Annual Max + Rollover**	**Benefits Paid**	**Eligible**	**Rollover *25% of Max***
1	$1,500	$450	Yes	$375
2	$1,875	$850	No	$0
3	$1,875	$450	Yes	$375
4	$2,250	$0	No	$0
5	$1,500	$450	Yes	$375

PRINCIPAL DENTAL OUT OF NETWORK CHARGES

Employees can maximize their dental benefits and reduce their out-of-pocket expenses by using network providers.

The example below shows the payment difference when an employee uses an in-network dentist versus a non-network dentist for a root canal on a molar. The non-network columns show possible charges with a prevailing fee percentile of 99. Principal uses these prevailing dentals fees to ensure claims reimbursements are aligned with current dentist changes. To calculate the prevailing fees, Principal Dental looks at dentist charges within a defined geographic region based on ZIP codes. The prevailing fee is the maximum dollar amount reimbursed for each service.

CLAIM PAYMENT EXAMPLE		
	In-Network Charges	**Non-Network Charges (99th Percentile)**
Fee Charged	$985	$985
Maximum Reimbursement Allowance *Fee schedule amount for in-network; Prevailing fee for non-network*	$650	$830
Dental Benefit Coinsurance at 80%	$520	$664
Employee Coinsurance at 20%	$130	$166
Difference employee pays between fee charged and maximum reimbursement allowance	NA	$155

This example is for illustrative purposes only and is not intended as a comprehensive representation of circumstances surrounding the claims displayed, an inclusive representation of all claims, or a promise to pay specific claims.

ADDED DENTAL SERVICES

All members are eligible for second opinions from dental providers at 100%. This helps you make sure you get the best advice to make an informed decision about your care. Certain health conditions can put you or your covered dependents at risk for dental problems. That's why these extra dental benefits are available.

HEALTH CONDITION	EXTRA SERVICES
• Diabetes • Heart Disease • Pregnancy	• Additional cleaning (routine or periodontal), or • Scaling or root planning covered at 100% (if dentally necessary)
• Cancer – undergoing chemotherapy or head/neck radiation	• Fluoride treatment (up to 3 every 12 months) covered at 100%, and • Additional cleaning (routine)
• Autism • Down syndrome • Cerebral palsy • Muscular dystrophy • Spina bifida	• General anesthesia or intravenous sedation coverage for the removal of impacted teeth, removal of dental cyst and tumors, multiple restorative services for dependents under the age of five, periodontal osseous surgery, bone grafting, surgical removal of four third molars on the same date of services.

EMPLOYEE ASSISTANCE PROGRAM

COMPSYCH

Services provided through Miami County's partnership with CEBCO and ComPsych are provided to all Miami County employees and their household members for FREE.

Personal issues, planning for life events or simply managing daily life can affect your work, health and family. ComPsych® GuidanceResources® provides support, resources and information for personal and work-life issues.

FREE, CONFIDENTIAL COUNSELING

ComPsych provides **five free confidential counseling sessions for employees and all household members per presenting issue.** This no-cost counseling service helps you address stress, relationship and other personal issues you and your family may face. It is staffed by Guidance Consultants—highly trained Master- and Doctoral-level clinicians who will listen to your concerns and quickly refer you to in-person counseling and other resources for:

- Anxiety, depression, stress
- Grief, loss and life adjustments
- Relationships/marital conflicts

LEGAL GUIDANCE

Talk to an attorney by phone. If you require representation, you will be referred to a qualified attorney in your area for a free 30-minute consultation with a 25% reduction in customary legal fees thereafter.

- Divorce & family law
- Debt & bankruptcy
- Real estate transactions
- Civil & criminal actions contracts
- Landlord/tenant issues

WORKLIFE SOLUTIONS

Delegate your "to-do" list. Our Work-Life Specialists will do the research for you, providing qualified referrals and customized resources for:

- Finding child and elder care
- Hiring movers or home repairs contractors
- Planning events
- Locating pet care

FINANCIAL RESOURCES

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

- Retirement and estate planning, taxes
- Relocation, mortgages, insurance
- Budgeting, getting out of debt, bankruptcy and more

ACCESSING COMPSYCH RESOURCES 24/7

Mobile App

877.327.4452 Phone
800.697.0353 TTY
ComPsych Online

ORGANIZATION ID: EAPCEB

MENTAL HEALTH RESOURCES

HELP IS AVAILABLE WHEN AND WHERE YOU NEED IT.

EMERGENCY RESOURCES

Call or text 911 if you or someone you know is in immediate danger.

LIVEHEALTH ONLINE PSYCHOLOGY

Available for anyone enrolled on an Anthem health plan

Virtual therapy sessions available for employees and their family members who are enrolled in one of the Anthem health insurance plan.

LiveHealth offers short wait times that are typically scheduled within 7 days.

Connect through your Sydney app under CARE or call ***844-784-8409***

988 LIFELINE

Available for anyone

Whether you're facing mental health struggles, emotional distress, alcohol or drug use concerns, or just need someone to talk to, caring counselors are here for you. You are not alone.

988 - Call. Text.

988lifeline.org - Chat. ASL Now.

24-HOUR TRI-COUNTY CRISIS HOTLINE

Available for anyone living in Darke, Miami & Shelby counties

If someone you know is in crisis and needs help, please call the Tri-County CRISIS Hotline at **800-351-7347**.

Can't Call? Text "4hope" to 741 741

EMPLOYEE ASSISTANCE PROGRAM

Free for all employees & their household members

ComPsych offers employees and their household members 5 free in-person or virtual counseling sessions per per issue per person every year.

You must call to initiate this service.

877-327-4452 (Organization ID: EAPCEB)

LIVEHEALTH ONLINE PSYCHIATRY

Available for anyone enrolled on an Anthem health plan

Visit LiveHealth online to access virtual sessions with a board-certified psychiatrist for medication management.

Connect through your Sydney app under CARE or call ***888-548-3432***

BEHAVIORAL HEALTH RESOURCE CENTER

Available for anyone enrolled on an Anthem health plan

Access to case managers who will work with you to understand your condition, develop personalized goals, connect you with local and online resources, and help ensure you're getting all the benefits available under your health plan.

Case managers are licensed mental health professionals.

Connect through your Sydney app under MY HEALTH DASHBOARD > PROGRAMS for live chat or call ***844-451-1576***

LIFE & AD&D INSURANCE

www.mutualofomaha.com 1.888.525.0787

Life insurance can be a key component of your financial plan. Learn about plan types, how the plans work, and which option is the right fit for you and your family by visiting Mutual of Omaha's online resources.

Evidence of Insurability (EOI) is required by Mutual of Omaha for requested coverage above specific amounts and for specific changes. You will receive instructions on how to complete the EOI online, if required. If you are required to submit an EOI for approval, your new deductions will not begin until notification of approval has been received from Mutual of Omaha.

ENROLLMENT OPPORTUNITY	EOI REQUIREMENT
New Hire	EOI will be requested in you are requesting coverage greater than ten times your annual salary or $100,000, whichever is less
Qualifying Life Event	EOI requested for all changes
Open Enrollment – Increases Existing Coverage	EOI requested for increases greater than $10,000
Open Enrollment – New Enrollment	EOI requested for enrollment if you previously declined additional coverage

You are required to list at least one primary beneficiary for your life benefits during enrollment. You are also strongly encouraged to list at least one contingent beneficiary.

COUNTY-PAID COVERAGE

Beginning January 1, 2025 Miami County will increase the amount of the **FREE** Life and Accidental Death and Dismemberment ("AD&D") policy to $50,000 for all eligible employees. The county-paid amount is subject to a reduction of 35% at age 75 and 70% at age 80.

VOLUNTARY LIFE & AD&D INSURANCE

Miami County employees can purchase additional life and AD&D insurance for themselves and their spouses, in addition to their County-paid policy. You may elect AD&D coverage for your spouse if you have also elected additional coverage for yourself. The amount you elect for your spouse cannot exceed the amount you elected.

RATES

AD&D coverage, regardless of age, is $0.01 per month per $1,000 of coverage elected. Life insurance rates are shown in the table to below by age group. Life insurance rates are based on the individual's age. To calculate your payroll deduction, find the rate based on your age group (or your spouse's age group, if applicable) as of January 1, 2025. Divide the amount of life insurance you are requesting by $1,000 and multiply this number by the age rate.

AGE	RATE/$1,000 OF COVERAGE
<29	$0.04
30 – 34	$0.05
35 – 39	$0.07
40 – 44	$0.11
45 – 49	$0.17
50 – 54	$0.26

AGE	RATE/$1,000 OF COVERAGE
55 – 59	$0.41
60 – 64	$0.55
65 – 69	$0.92
70 – 74	$1.46
75 – 79	$3.08
80+	$6.84

RATE CALCULATION EXAMPLE

Age	Rate/$1,000 of Coverage
<29	$0.04
30 – 34	$0.05
35 – 39	$0.07
40 – 44	$0.11
45 – 49	$0.17
50 – 54	$0.26
55 – 59	$0.41
60 – 64	$0.55
65 – 69	$0.92
70 – 74	$1.46
75 – 79	$3.08
80+	$6.84

Amelia is 48 years old & applies for $150,000 in life insurance.

A. Divide the amount of life insurance by $1,000. $\frac{150{,}000}{1{,}000} = \mathbf{150}$

B. Multiply Amelia's age rate by the answer from A. $150 \times \$0.17 = \$\mathbf{25.55}$

If approved, Amelia will have a deduction of $25.55 per check.

Amelia also wants to apply for $50,000 of life insurance for her husband who is 55.

A. Divide the amount of life insurance by $1,000. $\frac{50{,}000}{1{,}000} = \mathbf{50}$

B. Multiply spouse's age rate by the answer from A. $50 \times \$0.41 = \$\mathbf{20.50}$

C. Add the amount from the first example and the amount from this example for the total payroll deduction.

If approved, Amelia will add $20.50 to her original deduction for her spouse's life insurance, for a total $46.05 per check.

GUARANTEE ISSUE AND MAXIMUM AMOUNTS

The guarantee issue (GI) amounts shown below with an asterisk are the maximum amounts new hires may request without completing an EOI form for approval.

Employee Incremental Amount	$10,000
Employee Guarantee Issue *	10 times your annual earnings or $100,000, whichever is less.
Employee Maximum Amount	$230,000
Spouse Incremental Amount	$5,000
Spouse Guarantee Issue *	Up to $25,000
Spouse Maximum Amount	$200,000 (Cannot exceed 100% of employee benefit)
Reduction Schedule	Age 65 – 35% * Age 70 – 60% * Age 75 – 75% * Age 80 – 85%

VOLUNTARY CHILD LIFE

Miami County employees can also purchase a child policy in increments of $2,500 up to $10,000.

INSURED AMOUNT	$2,500	$5,000	$7,500	$10,000
PAYROLL DEDUCTION	$0.21	$0.42	$0.63	$0.84

RETIREMENT RESOURCES

OHIO PUBLIC EMPLOYEE RETIREMENT SYSTEM (OPERS)

All full-time Miami County employees are required to contribute to the Ohio Public Employee Retirement System (OPERS).

EMPLOYEE TYPE	EMPLOYEE CONTRIBUTION	COUNTY CONTRIBUTION
SHERIFF DEPUTIES	13.0%	18.1%
ALL OTHER COUNTY EMPLOYEES	10.0%	14.0%

Employees have 180 days from their start date to select one of the two retirement plans offered through OPERS.

OPERS offers phone, virtual, and in-house counseling options to provide guidance to employees preparing to receive their pension. Visit http://www.opers.org or call 1-800-222-7377 to learn about enrollment, counseling, retirement, refunds, and more.

Member Handbook

The OPERS Member Handbook is a great place to start learning about your benefits with OPERS. It is a comprehensive overview of the benefits of membership with OPERS. Scan or click to review.

Retiring from Public Employment

Traditional | Member Directed | Combined

As you begin to consider retirement and make the transition from active member to retiree, you need to have a full understanding of the retirement application process under your chosen retirement plan. This includes documents required to process your application and important dates and deadlines. Scan or click the codes to find out more about this process with your chosen plan.

Returning to Work After Retirement

Once you retire under any of the OPERS retirement plans, re-employment in a job that is covered by OPERS, including service in an elected position, may affect continuing receipt of benefits. Retirees who become re-employed must notify the employer that they are receiving an OPERS retirement benefit. Scan or click to learn more.

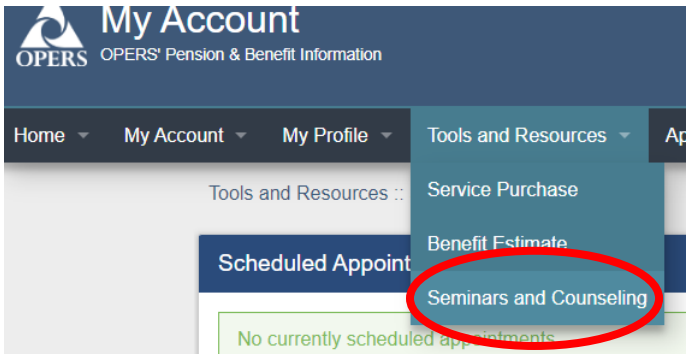
Returning to Work

Scheduling an Appointment with OPERS

Members have three options to schedule an appointment with OPERS:

- In-House Counseling
- Phone Counseling
- Virtual Counseling (Zoom)

To schedule one of these appointments, log into your OPERS account at opers.org, then go to Tools and Resources > Seminars and Counseling.



DEFERRED COMPENSATION (457 PLAN)

Any public employee who is eligible for OPERS membership is also eligible to enroll in a 457(b) deferred compensation plan. A governmental 457(b) deferred compensation plan is a voluntary retirement savings plan that allows participants to supplement existing retirement/pension benefits by saving and investing pre-tax dollars through payroll contributions. Contributions are tax-deferred (both federal and state income taxes) until money is withdrawn.

With a 457(b) plan, employees can put some of their taxes on hold by reducing the amount of taxes withheld from their pay. Withdrawals are taxed as ordinary income. These plans also have an option to automatically increase annual contributions, rollover options from other retirement/pension plans, flexible withdrawal options for unforeseeable emergencies, and more.

Scan or click the code to the left for the OPERS Saving for Retirement guide to learn more about OPERS and deferred compensation with the OPERS Guide to Saving for Retirement.

Employees have the option to choose from two plans, both of which are listed below. There are differences between the plans and you are encouraged to reach out to the contacts listed for more information. Once enrolled, the plans communicate directly with Miami County payroll to initiate deductions.

Ohio Deferred Compensation
Steve Schmittauer, Account Executive
937.284.1212 | Schmits3@nationwide.com
www.ohio457.org

Ohio County Employees Retirement Plan (OCERP)
(formerly known as CCAO457 Deferred Compensation)
Matt Hambrick, Retirement Plan Advisor
380.239.7768 | matt.hambrick@empower.com
https://ccao457.empower-retirement.com/

EDUCATION RESOURCES

PUBLIC SERVICE LOAN FORGIVENESS (PSLF)

The PSLF Program forgives the remaining balance on Direct Loans after an employee has made 120 qualifying monthly payments under a qualifying repayment plan while working full-time for a qualifying employer.

To qualify for PSLF, you must be employed full-time by a U.S. federal, state, local, or tribal government or not-for-profit organization (this qualification includes U.S. military service), have Direct Loans (or consolidate other federal student loans into a Direct Loan), repay loans under an income-driven repayment plan, and make 120 qualifying payments.

Employment with Miami County may qualify you for participation in this program. Visit https://studentaid.gov/manage-loans/forgiveness-cancellation/public-service for more information.

FRANKLIN UNIVERSITY TUITION DISCOUNT

Miami County employees and their dependents are eligible for a 20% discount on tuition and free books through the County's partnership with the Troy Area Chamber of Commerce.

Visit https://www.franklin.edu/admissions/partnership-students for more information.

FITNESS CENTER MEMBERSHIPS

LINCOLN COMMUNITY CENTER - FREE

All Miami County employees and their spouses are eligible for **free memberships** to the Lincoln Community Center. Dependents 21 and under receive free memberships automatically from LCC.

When you join the Lincoln Community Center, you have access to:

- Weight room
- Heated pool
- Walking track
- Gym
- Outdoor basketball courts
- Basketball leagues
- Pickleball
- Sports training & conditioning
- Volleyball
- Vibe Fitness (additional fee)
- Yoga
- Plus much more!

Visit Lincoln Community Center at 110 Ash Street in Troy today to sign up for your free membership!

MIAMI COUNTY YMCA - DISCOUNT

IMPORTANT NOTICE ABOUT MEMBERSHIP USAGE:
Employees who do not use their membership for three consecutive months will lose their membership discount. This program is available only for monthly memberships.

All Miami County employees and their families receive a **30% discount off membership fees** with the Miami County YMCA. 2025 rates will be released in December 2024. The rates shows below reflect the current rates.

The Miami County YMCA has two conveniently located branches:

Piqua Branch
223 West High Street, Piqua, OH 45356
937.773.9622

Robinson Branch
3060 South County Road 25A, Troy, OH 45373
937.440.9622

Membership includes:

- Unlimited access to both branches
- Free child watch and family fun nights
- Open swim for adults and families
- Open gym
- Program guides delivered to your home
- Member classes and program rates
- Priority registration for all programs
- AWAY privileges (Always Welcome at YMCAs)

Membership Type	Enrollment Fee	Monthly Fee*
Youth	$16.05	$10.86
Adult	$37.45	$26.96
Senior Adult	$37.45	$24.34
Single Parent Family / Couple / Household	$53.50	$36.01
Senior Couple	$53.50	$32.49
Family	$53.50	$43.82
Health Center Membership (Single Adult)	No additional enrollment fee	$32.19
Health Center Membership (Senior Adult)		$28.98
Health Center Membership (Couple)		$41.46
Health Center Membership (Senior Couple)		$37.27

**Monthly fees are applicable to Bank Draft only.*

AFLAC

Miami County offers four supplemental insurance plans through a partnership with Aflac, as listed below. All Aflac plan details and rates are explained in detail with individual brochures in UKG.

ACCIDENT

The Accident Plan covers items such as:

- Ambulance rides
- Emergency room visits
- Surgery and anesthesia
- Prescriptions
- Major Diagnostic Testing
- Burns

Benefits are paid directly to you, unless otherwise assigned. Coverage is guaranteed-issue (you may qualify for coverage without having to answer health questions.)

CRITICAL ILLNESS

This plan can help with the treatment costs of covered critical illnesses, such as a heart attack or stroke. With the Critical Illness plan, you receive cash benefits directly (unless otherwise assigned.)

HOSPITAL INDEMNITY

The Aflac Group Hospital Indemnity plan benefits include the following:

- Hospital Confinement Benefit
- Hospital Admission Benefit
- Hospital Intensive Care Benefit
- Successor Insured Benefit

SHORT TERM DISABILITY

This plan is for off-job claims (i.e., non-Workers Compensation claims) and includes:

- Up to 60% of your salary when you are sick/hurt and unable to work
- Minimum and Maximum Total Monthly Benefit – $300 to $6,000
- Premium payments waivers after 90 days of total disability
- Partial Disability Benefit

Deductions for this benefit begin after the additional evidence of insurability paperwork has been reviewed and approved.

A NOTE FROM AFLAC REGARDING COVERAGE

Aflac always strives to put their customers' best interests first. Therefore, as part of each open enrollment, you are encouraged to conduct an annual audit of your insurance policies. Important things to consider are:

- Understanding the benefits of all your policies and ensuring you are not enrolling in duplicate coverage
- Ensuring your dependent and beneficiary information is up to date
- Verifying your contact information is accurate

For more information, contact:

Susan Svarda, AFLAC Associate
PH: 937.730.0067 / F: 937.730.0068
susan_svarda@us.aflac.com

ANNUAL NOTICES

FOR MORE INFORMATION ABOUT THESE NOTICES, PLEASE CONTACT HUMAN RESOURCES AT 937.440.5996.

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For an individual receiving mastectomy-related benefits, coverage will be provided in a manner determined by 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 an asymmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the deductibles and coinsurances described on pages 13 - 25 apply.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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

SPECIAL ENROLLMENT

If you are declining enrollment for you or your dependents (including your spouse) because of other health insurance coverage, you may, in the future, be able to enroll you or your dependents in the plan, provided that your request enrollment within 30 days after your other coverage ends (COBRA or state continuation coverage ends, divorce, legal separation, death, termination of employment or reduction in hours worked; or because the employer contributions cease).

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll you and your dependents, provided you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

PREMIUM ASSISTANCE UNDER MEDICAID & 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 are not 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 DOL at www.askebsa.dol.gov or call 1-866-444-EBSA (3272). To see if any other states have added a premium assistance program since 07/31/21, or for more information on special enrollment rights, contact either:

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

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

2025 PAYROLL CALENDAR

PAY PERIOD	PAY DATE
12/21/2024 - 1/3/2025	1/10/2025
1/4/2025 - 1/17/2025	1/24/2025
1/18/2025 - 1/31/2025	2/7/2025
2/1/2025 - 2/14/2025	2/21/2025
2/15/2025 - 2/28/2025	3/7/2025
3/1/2025 - 3/14/2025	3/21/2025
3/15/2025 - 3/28/2025	4/4/2025
3/29/2025 - 4/11/2025	4/18/2025
4/12/2025 - 4/25/2025	5/2/2025
4/26/2025 - 5/9/2025	5/16/2025
5/10/2025 - 5/23/2025	5/30/2025*
5/24/2025 - 6/6/2025	6/13/2025
6/7/2025 - 6/20/2025	6/27/2025
6/21/2025 - 7/4/2025	7/11/2025
7/5/2025 - 7/18/2025	7/25/2025
7/19/2025 - 8/1/2025	8/8/2025
8/2/2025 - 8/15/2025	8/22/2025
8/16/2025 - 8/29/2025	9/5/2025
8/30/2025 - 9/12/2025	9/19/2025
9/13/2025 - 9/26/2025	10/3/2025
9/27/2025 - 10/10/2025	10/17/2025
10/11/2025 - 10/24/2025	10/31/2025*
10/25/2025 - 11/7/2025	11/14/2025
11/8/2025 - 11/21/2025	11/28/2025
11/22/2025 - 12/5/2025	12/12/2025
12/6/2025 - 12/19/2025	12/26/2025

NOTES


EMPLOYEE
BENEFITS
AT MIAMI COUNTY