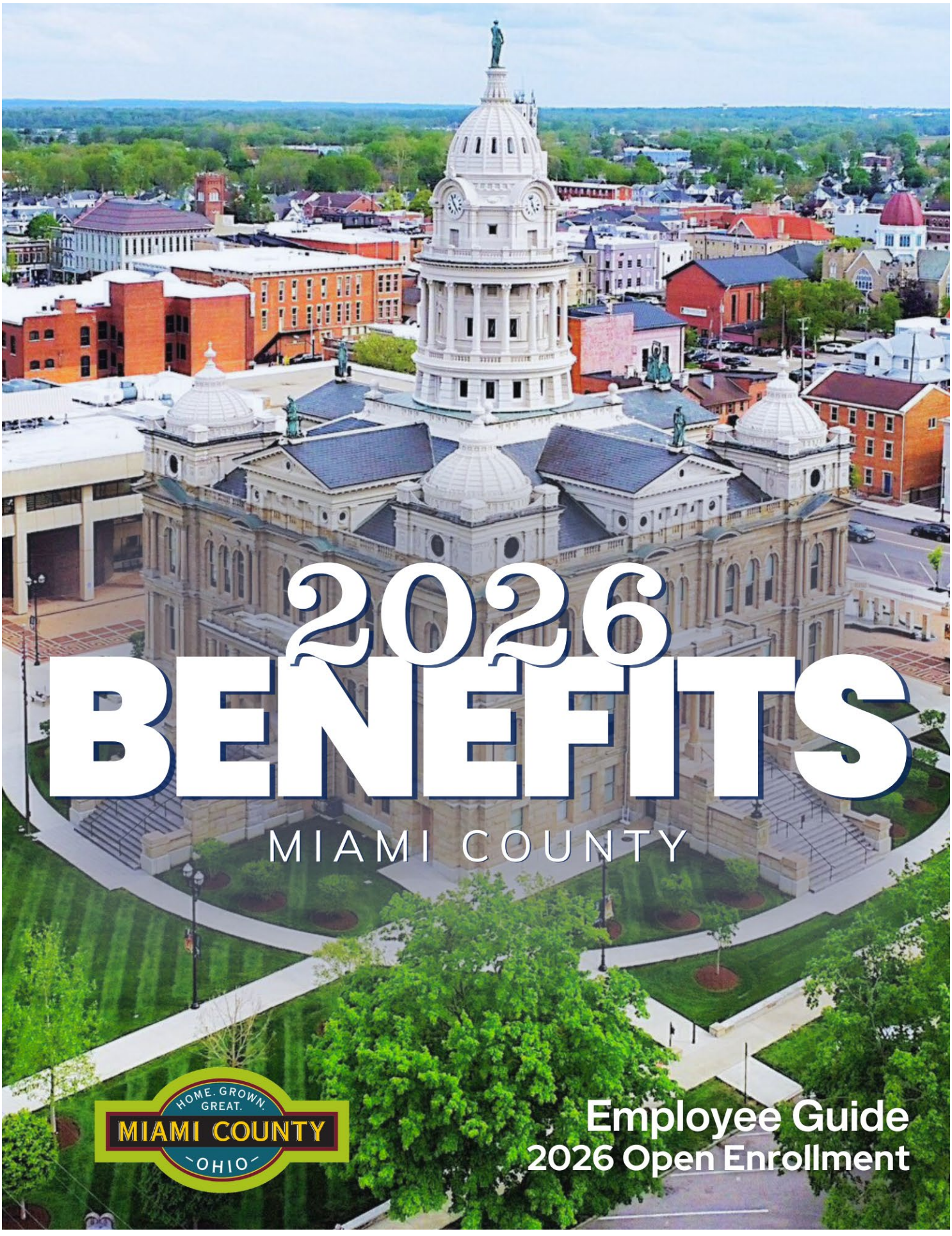

2026
BENEFITS
MIAMI COUNTY
HOME. GROWN. GREAT.
MIAMI COUNTY
OHIO
Employee Guide
2026 Open Enrollment

A Message from Miami County Human Resources

In October, the Board of Miami County Commissioners approved the renewal contract with the County Employee Benefits Consortium of Ohio (CEBCO), the group through which we participate for our health insurance coverage. This partnership continues to provide meaningful value to both employees and taxpayers, allowing us to maintain comprehensive and affordable benefits. For 2026, Miami County received a 10.9% renewal, a result that remains competitive in today's challenging healthcare market.

As dental premiums continue to rise across the industry, we remain committed to maintaining access to quality care—including coverage for the growing number of local providers who no longer accept insurance. Employees will see an **18% increase in dental premiums for 2026,** but there will **be no increase in dental rates for 2027**.

We are also pleased to announce that our supplemental insurance plans, previously offered through Aflac, will transition to Assurity beginning in 2026. Employees can expect enhanced plan options, improved customer service and claims processing, and access to additional term-life insurance offerings.

All benefits described in this guide are effective January 1, 2026. Inside, you'll find details about plan options, eligibility, and the enrollment process. I encourage you to review this guide carefully and take full advantage of the programs and resources available to support your health and financial well-being.

I want to extend my sincere appreciation to the Board of Commissioners, the Insurance Committee, and our benefits broker, Benefits Analysis Corporation, for their collaboration and diligence throughout this renewal process.

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

Angela Lewis

Human Resources Director
Board of Miami County Commissioners

QUESTIONS?

HR is here to help you 24/7 with any questions or concerns you may have throughout the enrollment process and beyond. Through the ASK HR feature (scan the QR code to the right), you can schedule an appointment to meet with an HR team member individually or submit your question and we will respond within 24 business hours.

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.

TABLE OF CONTENTS

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 (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.

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.

ELIGIBILITY

Rates and plans included in this guide will be effective on January 1, 2026 and remain in effect through December 31, 2026. **NEW HIRES must complete their benefit enrollments within 30 days of their start date with Miami County.**

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 Stepchildren: 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 PER 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
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			●
Anytime Fitness Troy	N/A		●	●		Anytime			●
Assurity	N/A		●		●	Anytime			●

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.

2026 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. Payroll deductions are taken one month in advance for all benefits except Aflac, HSA, and Flex Spending, which are taken for the current month. ***A printable 2026 Payroll Calendar can be found at the end of this guide.***

EMPLOYEE BENEFITS SELF-SERVICE-UKG READY

1 NAVIGATE TO UKG

Scan/click the QR code, click on Benefits Self-Service Portal at help.miamicountyohio.gov, or download the **UKG Ready** app from the App Store or Google Play.

UKG is available from any location - you do not need to be on Miami County's system.

2 CREATE OR LOG INTO YOUR UKG ACCOUNT

Company Short Name: 6163172

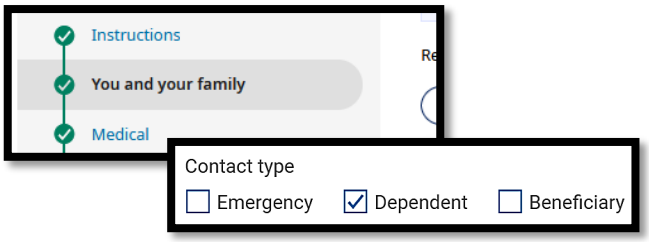
Username: First Initial + Last Initial + Last 4 of SSN
Example: Susie Hire 110-02-2023 = SH2023

Forgotten Password: Click **FORGOT PASSWORD**

3 START NEW EMPLOYEE ENROLLMENT

Click on **MY BENEFITS** > **START OPEN ENROLLMENT**

4 REVIEW YOUR CONTACT INFORMATION



Review contacts, dependents, and beneficiaries by clicking on **YOU AND YOUR FAMILY**.

Each contact must have ***at least one*** box checked.

- EMERGENCY: Contact in case of an emergency
- DEPENDENT: Listed as a possible enrollee for applicable benefits.
- BENEFICIARY Listed as a possible beneficiary on applicable benefits.

5 MAKE YOUR BENEFIT ELECTIONS

Review each benefit screen carefully. Your 2025 elections will be shown on each screen.

Be sure to click **SUBMIT** when you are finished making your elections.

HEALTH INSURANCE PLANS

Miami County employees have a choice between a traditional embedded PPO plan and an embedded high-deductible plan (HDHP) in 2026.

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.

Your Biweekly Deduction	PPO	HDHP
Employee	$104.50	$55.54
Employee + Spouse	$230.21	$122.35
Employee + Child(ren)	$187.79	$99.80
Family	$313.50	$166.61

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.

Summary of Benefits and Coverage for both plans can be found at the back of this guide.

CHOOSING A PLAN WISELY

When choosing a health plan, don't just look at the deductible. Think about:

- Your **per-paycheck premium** (what comes out of your pay)
- Your **out-of-pocket costs** if you need care
- Miami County's **HSA contributions** (for the HDHP)

The right plan depends on how often you expect to use care and how much risk you're comfortable with.

PPO	HDHP
•Deductible: $500 •Max Out of Pocket: $2,500 •Co-Insurance: 20%	•Deductible: $3,500 •Max Out of Pocket: $3,500 •Co-Insurance: N/A

EXAMPLE 1

Abigail visits the ER in January. The hospital bill after the insurance discount is **$2,500**.

PPO	HDHP
•Abigail meets her deductible right away: $500 •She pays the 20% coinsurance: $400 •Her total cost is: **$900**	•Abigail pays the full amount of the bill: $2,500 •She uses her Q1 HSA contribution: -$250 •Her total cost is: **$2,250**
Remaining Amounts	***Remaining Amounts***
•Deductible: $0 *•Max Out of Pocket: $1,600*	*•Deductible: $1,000* *•Max Out of Pocket: $1,000*

EXAMPLE 2

It is now May and Abigail needs a procedure done. The hospital bill after the insurance discount is **$1,000**.

PPO	HDHP
•Abigail already met her deduction: $0 •She pays the 20% coinsurance: $200 •Her total cost is: **$200**	•Abigail pays the rest of her deductible: $1,000 •She uses her Q2 HSA contribution: -$250 •Her total cost is: **$750**
Remaining Amounts	***Remaining Amounts***
•Deductible: $0 *•Max Out of Pocket: $1,400*	*•Deductible: $0* *•Max Out of Pocket: $0*

It is also important to keep in mind that it costs more per pay to be on the PPO plan. For Abigail, she would pay $44.15 more per pay, or $1,059.60 annually, to be on the PPO plan.

She would receive a County HSA contribution of $250 quarterly, or $1,000 annually, if she enrolled in the HDHP plan. In the examples above, she was able to use $500 of those contributions to off-set her out-of-pocket expenses.

HOW ANTHEM 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: 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: 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.

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 but be sure to 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.

Questions about how your claim was processed? Anthem's claim processing team members are well-equipped to explain why a service was paid in a particular manner and have the most complete information regarding your claim.

CEBCO DIABETIC SUPPLY BENEFIT

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:

- Lancets
- Test Strips
- Needles
- Syringes
- Ketone Strips

COINSURANCE RESPONSIBILITY:

- Meters
- Alcohol Swabs
- Freestyle Libre
- Freestyle Libre 2
- Dexcom G6
- Omnipod
- Omnipod Dash

DEDUCTIBLE & COINSURANCE:

- Infusion Sets
- Reservoirs
- Insulin Pump
- Tubing
- Pump Supplies

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

CEBCO's benefits for diabetic supplies follow accepted insurance guidelines.

HEALTH SAVINGS ACCOUNT

www.parknationalbank.com 1.888.474.7275

THESE ACCOUNTS ARE ONLY FOR THOSE INDIVIDUALS ENROLLED IN THE HIGH-DEDUCTIBLE HEALTH PLAN

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 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 contributes money quarterly into a health savings account for employees enrolled in the high-deductible health plan. The funds are distributed equally on the 10th (or the first business day following) of January, April, July, and October.

To be eligible for an HSA contribution, you must have an HSA set up with Park National Bank and be:

- in an active pay status with Miami County on the day the funds are distributed, and
- enrolled a high-deductible health plan through Miami County

Maximum Contribution Amounts

The County contributions and any individual contributions you choose to make cannot exceed the 2026 IRS limits.

ENROLLMENT LEVEL	IRS LIMIT	COUNTY CONTRIBUTION	MAX EMPLOYEE CONTRIBUTION
Individual	$4,400	$1,000	$3,400
Family	$8,750	$2,000	$6,750
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 one of branches below to set up your account. If you are unable to go to a location during regular business hours, contact HR 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 & 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. Also, per IRS regulations, **individuals must cease HSA contributions six months prior to their Medicare effective date**.

PREVENTATIVE DRUG LIST

THIS BENEFIT APPLIES ONLY FOR THOSE INDIVIDUALS ENROLLED IN THE HIGH-DEDUCTIBLE HEALTH PLAN

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

Anthem

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 BENEFIT APPLIES ONLY FOR THOSE INDIVIDUALS ENROLLED IN THE HIGH-DEDUCTIBLE HEALTH PLAN

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

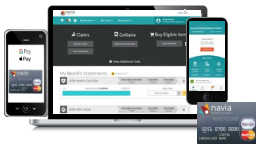
FLEXIBLE SPENDING ACCOUNTS

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, 2026 and March 15, 2027. 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.

ENROLLEES IN A HIGH-DEDUCTIBLE HEALTH PLAN ARE NOT ELIGIBLE TO ENROLL IN THIS ACCOUNT.

Your contributions to the Health Care account cannot exceed the annual limit set by the IRS, which for 2026 is expected to increase to $3,400 when the IRS releases final limits later this year.

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

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.

¿Prefieres obtener información en español?

Tienes opciones. Si tu teléfono móvil ya está configurado en español, la aplicación Sydney Health también estará en español. Si no es así, selecciona el **menú** dentro de la aplicación Sydney Health y elige **el idioma de la aplicación**. También puedes visitar **anthem.com/es**.

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 provider in your plan's network. If you receive care from a doctor or healthcare provider 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. ©2024 The Virtual Primary Care experience is offered through an arrangement with Hydrogen Health.

116947MUMENABS VPOD BV Rev. 12/22

Meet your new favorite health plan benefit!

During open enrollment it's important to know all your options. As an Anthem member, you'll have SmartShopper. It's a simple to use tool that compares locations so you can save money and earn cash rewards on routine medical care.

Earn cash rewards up to $500 with SmartShopper

Since SmartShopper is part of your benefits, there are no extra steps or fees. It's quick & easy to compare costs and cash reward amounts before scheduling your procedure. And the best part? Your cash reward will be sent automatically.

It's Simple To Use

Compare locations at **SmartShopper.com** or call the Care Concierge Team at **866-285-7078**.

Schedule your appointment or let the Care Concierge Team do it for you.

Earn your cash reward by having your appointment within the year.

The Care Concierge Team is here to support you. Not only can they help you compare costs, but they can even take care of prior authorizations and scheduling your procedure for you. Call today!

Go green by going paperless! Scan the QR code or contact us to register your email today.

The Care Concierge Team is available Monday through Thursday from 8 a.m. to 8 p.m. and Friday from 8 a.m. to 6 p.m. ET.*

Anthem

SmartShopper®

*Summer hours: The Care Concierge Team closes at 3 p.m. ET on Fridays from Memorial Day to Labor Day.

The SmartShopper program is offered by MDX Medical, LLC, a Zelis company. Reward-eligible options and reward amounts are subject to change. Rewards are available for select procedures only. Rewards may be a taxable form of income. MDX Medical, LLC, a Zelis company, does not provide tax advice. Rewards may be delivered by check or an alternative form of payment. Members with primary coverage under Medicaid or Medicare are not eligible to receive incentive rewards under the SmartShopper program.

LiveHealth® ONLINE

Get care from anywhere

Virtual visits on LiveHealth Online are an included benefit for Anthem members

Get the care you need, virtually.

Looking for a quick and easy way to get care? With LiveHealth Online, you can access telehealth visits from anywhere. All you need is a smartphone, tablet, or computer!

Care options available to you through LiveHealth Online:

Annual Wellness. Visit with a primary care provider who can help with preventative screenings, chronic health concerns, and referrals for lab work and specialists as clinically appropriate. Annual wellness visits are an important part of maintaining good health, managing chronic conditions, and preventing potential health issues.

Virtual Primary Care. Get regular health visits and checkups with virtual primary care. It's like an office visit with a primary care provider (PCP) — without the office. You can even choose to see a network PCP regularly, so you have the same provider taking care of you over time.

Urgent Care. Get care 24/7 for common health issues, including allergies, COVID-19 symptoms, the flu, sinus infections, and UTIs. Physicians assess your symptoms, provide a treatment plan, and send prescriptions to the pharmacy of your choice when needed.

Allergy. Doctors can provide a treatment plan and send prescriptions to the pharmacy of your choice anytime. No need to wait to feel better. Doctors can treat common allergy symptoms including itchy, puffy, and watery eyes, congestion, runny nose, itchy throat, and more.

Therapy and Psychiatry. See a therapist online from the comfort of your couch to get help for anxiety, depression, panic attacks, stress relief, and more. Psychiatrists are also available by appointment and can prescribe medication when talk therapy isn't enough.

SCAN ME

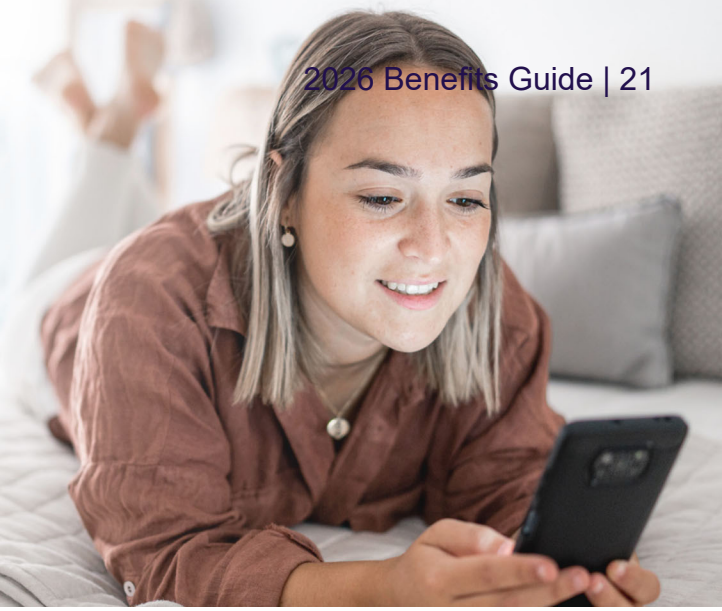
Get started today! LiveHealth Online is available through the Sydney℠ Health and LiveHealth Online apps, or Anthem.com and LiveHealthOnline.com

LiveHealth Online is offered through an arrangement with Amwell, a separate company, providing telehealth services on behalf of your health plan.

Anthem

Receive virtual care and support

through our Sydney Health mobile app



When you aren't feeling your best—physically, mentally, or emotionally—or you need guidance managing a health condition, help is available. You can connect to the care you need using our **Sydney℠ Health** mobile app. You can have a video visit with a doctor 24/7 for common health issues and annual wellness visits. Care for mental and emotional health is available by appointment.[1] Plus, the Sydney Health app is your avenue to specialized programs designed to help you improve your habits and your health.

Visit with a doctor for common medical concerns

Doctors are available anytime, with no long wait times and no appointments needed. They can help you with health issues, such as a cold or the flu, allergies, sore throat, migraines, or skin rashes. During your private and secure video visit, the doctor will assess your condition, provide a treatment plan, and send prescriptions to the pharmacy of your choice, if needed.[3]

Receive care for your behavioral health

If you're feeling anxious or depressed, or having trouble coping, you can set up a video visit with a therapist, psychologist, or psychiatrist.[4] Appointments can be scheduled within one to two weeks.[1] Psychiatrists help manage medications; they do not provide counseling or talk therapy.[5]

What people say about virtual care visits[2]

92% were able to book a virtual visit sooner than an in-person visit

89% said the doctor they saw was professional and helpful

92% thought the doctor understood their concerns

How to download our Sydney Health app:

Scan the QR code with your phone's camera.

Download on the App Store

GET IT ON Google Play

sydney℠

County Employee Benefit Consortium of Ohio CEBCO Health & Wellness

Anthem

Skip monthly trips to the pharmacy with our 90-day benefit

You can even save money!

Not one for going to the pharmacy every month and standing in line to refill your prescriptions? There's no need. With our 90-day benefit options, you'll have the convenience of getting the medicine you need with fewer trips to the drugstore. You can even have it delivered to your door!

Here's something else that's great: When you get a 90-day supply of your medication, you're more likely to stay on track with your therapy and avoid emergency room visits, hospital stays or tests that may be needed when you miss doses.*

Best of all? This benefit is offered at no extra cost to you.

90-day fill required after two courtesy fills (30 days)

Rx Maintenance 90: Save time, stress and money!

Refill your prescriptions for a 90-day supply of maintenance drugs through Rx Maintenance 90. Maintenance drugs treat long-term conditions like asthma, heartburn or diabetes. Depending on your plan, you may even save on the cost of your prescriptions compared to what it would cost for three 30-day supplies.

When you use your Rx Maintenance 90 benefit, you must fill prescriptions for maintenance drugs at a Rx Maintenance 90 pharmacy, or through home delivery. Whether you choose a Rx Maintenance 90 pharmacy or home delivery, you'll pay the same home delivery copay! It's easy and convenient.

There are more than 25,000 pharmacies to choose from. Here's how to find one near you:

- Log on to anthem.com and choose **Pharmacy**.
- On the *Pharmacy* page, choose **Find a Pharmacy**.
- Enter your ZIP code or city.

On the go? Use the Sydney app to find nearby pharmacies.

Just download the app and log in. Next, choose **Prescriptions** and then **Find a Pharmacy**.

Start using your 90-day prescription benefit today and spend less time at the pharmacy!

* Schwab P et al. A retrospective database study comparing diabetes-related medication adherence and health outcomes for mail-order versus community pharmacy. ***J Manag Care Spec Pharm***, 2019 Mar;25(3):332-340.

114992MUMENABS VPOD 05/19

Anthem | lark

Preventing diabetes just got easier

SMART SCALE INCLUDED!

Introducing Lark Digital Health Coaching

People with prediabetes have higher than normal blood sugar which can substantially increase the risk of developing type 2 diabetes. People often don't even know they have prediabetes, because it can occur with no symptoms. The good news is that there are steps you can take now to decrease your risk.

Your employer has teamed up with Lark to bring you access to the tools you need to take those steps and prevent type 2 diabetes. Available 24/7 on your smartphone, the Lark Diabetes Prevention Program is included at no extra cost as a benefit of your health plan. If you qualify, you'll also get a digital scale with the opportunity to earn a Fitbit®.

Together we can help you:

- Create healthy eating habits
- Reach or maintain a healthy weight
- Make time for physical activity
- Manage stress levels
- Improve sleep quality
- Set and reach your health goals

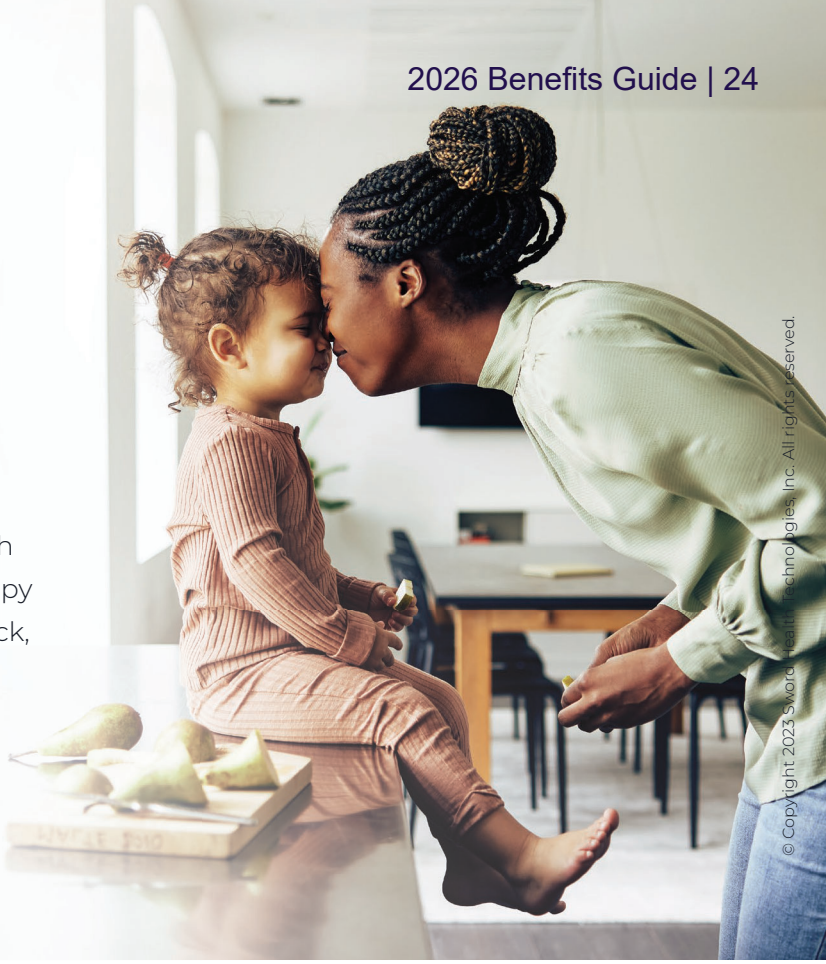
Get started with a quick eligibility survey

Scan this QR code with your smartphone camera to get started.

Or visit **lark.com/anthem**

Eligibility requirements for the Lark Diabetes Prevention Program include qualifying as prediabetic according to a survey designed by the Centers for Disease Control and membership in a participating health plan. You may be eligible to earn health-related devices such as a scale or Fitbit® at no cost to you. The ability to earn health-related devices may vary by health plan and may contain minimum program engagement requirements, such as weighing in, completing missions with your digital coach, and logging activity or meals. Eligibility determinations are made by Lark at its sole discretion.

Anthem | LiveHealth Online Healthy Back & Joints sword | County Employee Benefits Consortium of Ohio CEBCO Health & Wellness



Relieve aches + pain from the comfort of your home

Tired of chronic pain or loss of mobility? Struggling with discomfort? Meet Sword, the new digital physical therapy program designed to help you overcome your joint, back, or muscle pain—all from home.

Combining licensed PT with easy-to-use technology, Sword is more than just convenient. It's proven to work better than in-person physical therapy, too.[1]

Here's how it works

Pick Your PT

Thanks to your dedicated PT, your Sword program is entirely customized to you, your goals and your abilities.

Get Your Sword Kit

Your kit comes with your own tablet, and will provide you and your PT with real-time feedback.

Stay Connected

Chat 1:1 with your PT anytime. They'll check in, monitor your progress, and adjust your program as needed.

Feel the Relief

Complete your exercise sessions whenever is most convenient for you. Then feel pain relief for yourself.

Pain doesn't wait. Why should you?

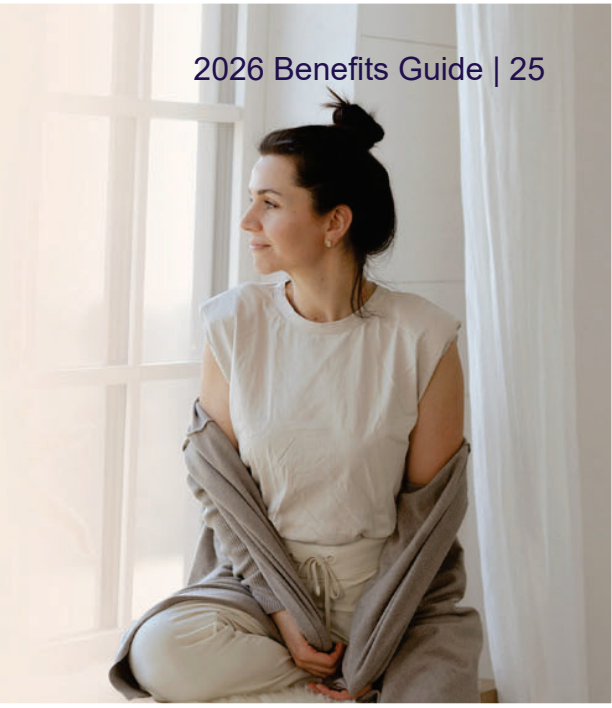
Enroll today to get started!

join.swordhealth.com/cebco/register

Sword is available at no cost to the employee, spouse, and dependents 18 and older on the Anthem Blue Cross and Blue Shield Medical Plan.
LiveHealth Online is the trade name of Health Management Corporation, a separate company, providing telehealth services on behalf of Anthem Blue Cross Blue Shield.

1 Correia, F. D., Nogueira, A., Magalhães, I., et al. (2018). Home-based rehabilitation with a novel digital biofeedback system versus conventional in-person rehabilitation after total knee replacement: A feasibility study. Scientific Reports, 8(1). https://doi.org/10.1038/s41598-018-29668-0

Anthem | LiveHealth Online Bloom: Women's Pelvic Health sword | County Employee Benefit Consortium of Ohio CEBCO Health & Wellness

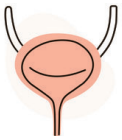


Bloom is your no-cost, **digital pelvic health** benefit.

1 in 3 women suffer from pelvic health disorders[1] including bladder issues, bowel dysfunction, and pelvic pain. Sword Health developed Bloom to give you relief with an easy-to-use, at-home pelvic therapy solution.

Here are some signs you may need pelvic therapy:

Leakage (bladder or bowel)



Pain or difficulty emptying bladder

You are, were, or are planning to be pregnant

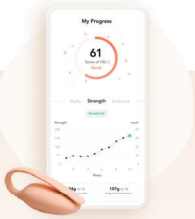
Pain or pressure in the lower abdomen

Pain during or after intimacy

What you get with Bloom

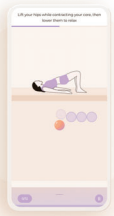
Expert Care

Bloom's Pelvic Health Specialists all have Doctor of Physical Therapy degrees and provide guidance throughout the program.



Innovative Tech

Women perform short pelvic-therapy sessions from home, using a safe, intravaginal pod that connects to a mobile app.



Real Results

Bloom sessions are fun and interactive. Members track progress and receive guidance through the app.

Activate your no-cost benefit today:

join.hibloom.com/cebco

Women's Pelvic Health is available at no cost to all US-based employees, spouses, and dependents 18 and older with vaginal anatomy, as a part of the Anthem medical benefits.

Scan to enroll

1 - Kenne, K.A., Wendt, L. & Brooks Jackson, J. Prevalence of pelvic floor disorders in adult women being seen in a primary care setting and associated risk factors. Sci Rep 12, 9878 (2022). https://doi.org/10.1038/s41598-022-13501-w

ComPsych | GuidanceResources®

County Employee Benefit Consortium of Ohio
CEBCO Health & Wellness

Life is challenging. We can *help*.

We're your GuidanceResources® program.

Talk to us for the tools you need to handle any of life's challenges, big or small.

Our Services:

Confidential Counseling

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

Work and Lifestyle Support

- Child, elder, and pet care
- Moving and relocation
- Shelters, government assistance

Legal Guidance

- Divorce, adoption, family law
- Wills, trusts, estate planning
- Free consultation and discounted local representation

Financial Resources

- Financial planning, retirement, taxes
- Relocation, mortgages, insurance
- Budgeting, debt, bankruptcy

Digital Tools and Support

- Immediate connection to counseling, work-life support, and more
- Personalized guided behavioral health and well-being programs
- Interactive articles, videos, on-demand trainings, digital self-care tools
- Accessible resources for anxiety, stress, mindfulness, sleep, and more

Explore your program: Scan for video tour!

Confidential 24/7 support, when and where you need it.

Call 877.327.4452 to speak to a highly trained, caring professional.

Go to guidanceresources.com and enter your company ID: EAPCEBX

Assistance is always confidential. View our privacy notice at **guidanceresources.com/privacy**

24/7 Live Assistance

Call: 877.327.4452
App: GuidanceNow℠
Online: guidanceresources.com
TRS: Dial 711
Web ID: EAPCEB

Scan for more resources

Anthem

Find mental health care that fits your needs

Headway can help

Whether you're looking for a mental health care provider or aren't sure where to start, Headway can help you find the right fit. As part of your benefits, you have access to a wide range of Headway therapists in your health plan's network who can get you the support you need.

From talk therapy to medication management, Headway offers:

Personalized matching
Get connected with the right care provider based on your needs and personal preferences.

Immediate availability
Receive same-day matching with care providers and appointments within 48 hours.

In-person or virtual care
Book a virtual or in-person appointment with care providers.

A comprehensive network of quality care providers
Access the right care with your choice of over 48,000 clinicians nationally.

A user-friendly digital platform
Book and manage appointments and payments directly on one website.

Cost-effective, transparent pricing
All Headway care providers are in your plan's network, so you can see pricing before you book.

If you're experiencing emotional distress, the resources below provide no-cost, confidential support 24/7. If this is an emergency, call **911** immediately.

Suicide & Crisis Lifeline
Call or text **988**.

Crisis Text Line
Text **HOME** to **741741**.

How to access Headway

1. Scan the QR code with your phone's camera or go to book.headway.co/anthem-bcbs.
2. Filter for your preferences, such as gender and language, to find the right care provider.
3. Add your health plan details and select an appointment.

You can also go to anthem.com or use the Sydney℠ Health app and select **Find Care** to search for Headway care providers.

Learn more

Visit **book.headway.co/anthem-bcbs** or contact Headway's support team at **646-941-7645** for more information.

Headway

Online counseling is not appropriate for all kinds of issues. If you are in crisis or have suicidal thoughts, it's important that you seek help immediately. Please call 988 (Suicide and Crisis Lifeline) or 911 and ask for help. If your issue is an emergency, call 911 or go to your nearest emergency room.

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

1080505MUMENABS 04/25

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**.

WELLNESS AT MIAMI COUNTY

Complete activities to earn rewards!

The CEBCO Rewards 200 program connects you with digital health and wellness tools that can help you live healthier. Complete any of the activities listed below between July 1, 2025, and June 30, 2026, and you'll earn up to **$200** in rewards to apply to electronic gift cards. This program, sponsored by your employer, is open to you and your covered spouse or partner.

ACTIVITY TYPE	ACTIVITIES	AMOUNT
Preventive Care Complete your annual screenings or wellness visits. Rewards are added to your account after your claim is processed (may take up to 60 days).	Have an annual preventative wellness exam or well-woman exam with your doctor.	$50
	Get an annual cholesterol test (men over 35 and women over 40). [1] [2]	$25
	Have a colorectal cancer screening (ages 45 and older)	$25
	Have a routine mammogram (women ages 40 to 74)	$25
	Have a prostate cancer screening (men ages 55 to 69)	$25
Condition Management Rewards are added to your account as you meet benchmarks or complete a program.	Work one-on-one with your ConditionCare health coach and earn rewards for participating in and completing the program.[3]	$25
	Receive two annual A1c tests (for members diagnosed with diabetes).[1]	$25
Digital & Wellness Activities Rewards are added to your account as you complete activities on the Sydney[SM] Health app or on anthem.com.	Log in to the **Sydney Health** app.	$25
	Complete a health assessment and receive tailored health recommendations.	$25
	Track your steps.	Up to $50 ($2 per 50,000 steps tracked)
	Complete team challenges throughout the year (four challenges are offered).	Up to $100 ($25 per challenge)

Earn and redeem your rewards

1. To view your rewards, log in to Sydney Health, or go to anthem.com.
2. Next, go to **Access Care** and select **My Health Dashboard.**
3. You can select **My Rewards** to see a snapshot of your reward status, as well as ways to earn more rewards.
4. You also can select **Redeem Rewards** to see how much you have earned.[4]

Use your rewards toward electronic gift cards for popular retailers, such as Amazon, Apple®, all Gap brands, Target, The Home Depot®, T.J. Maxx®, Uber, and Uber Eats. Minimum gift card amounts are set by each individual retailer.

You must redeem your rewards by September 30, 2026.

Scan this QR code to view your rewards on the Sydney Health app.[4]

Anthem

1 All preventive care activities and diagnostic A1c lab tests should be processed through Anthem Blue Cross and Blue Shield claims in order to trigger the respective reward.

2 Annual cholesterol test eligibility: men 35 years and older and women 40 years and older with a full cholesterol (lipid) panel.

3 Adult members identified as moderate or high risk are eligible for ConditionCare and may receive a reward for completion of one of five ConditionCare programs: chronic obstructive pulmonary disease, coronary artery disease, asthma, diabetes, and congestive heart failure. Reward is $25 for program completion.

4 Rewards must be redeemed by September 30, 2026. Minimum gift card amounts are set by each individual retailer.

We encourage you to actively participate in your rewards program. Rewards earned should be redeemed before the end of the current plan year. Unused rewards are forfeited three months after the end of your plan year.

All preventive care activities are claims based, which means your completion is determined when a claim is processed. Medical waivers apply to claim-based activities.

Rewards eligibility applies only to subscribers and their enrolled spouse or domestic partner. Members must be active on the plan, and their activity must take place during the plan year. A subscriber and spouse or domestic partner may earn rewards when eligible activities are completed and, in some instances, are verified by an Anthem claim.

The reward amount you receive may be considered income and subject to state and federal taxes in the tax year it is paid. You should consult a tax expert with any questions regarding tax obligations.

Electronic gift card availability may vary. The list of retailers available for electronic gift card rewards redemption is subject to change. Log on to anthem.com or open the Sydney Health app to see the electronic gift card options available to you.

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

VISION PLANS

www.vsp.com 1.800.877.7195

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

Your Biweekly Deduction	Plan A	Plan B
Employee	$4.20	$5.78
Employee + 1	$8.42	$11.58
Family	$12.75	$17.58

	PLAN A (005)		PLAN B (006)	
VISION EXAM	$10 Copay (Up to $39)			
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.*			

GET MORE AT PREFERRED IN-NETWORK LOCATIONS

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

DENTAL PLANS

Principal

www.principal.com 1.800.247.4695

Your Biweekly Deduction	Plan A (Low)	Plan B (High)
Employee	$16.29	$25.31
Employee + Spouse	$30.20	$47.88
Employee + Child(ren)	$33.75	$52.92
Family	$55.70	$87.70

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 (age limitations apply)	Not Covered	50% up to $1,000

Principal Dental Rollover Benefit

If you use 50% or less of your annual dental maximum in a given year and complete your routine preventive care visits, you can roll over 25% of that year's annual maximum to the following year.

You can continue to build your rollover amount each year, up to a maximum of 100% of your annual benefit limit.

How It Works

- Use 50% or less of your annual maximum and have your annual preventive care → You earn a 25% rollover for the next year.
- Use more than 50% → No rollover that year.
- Skip preventive care or have no claims at all → Rollover resets to $0.

This feature rewards members who maintain regular preventive care and helps you build extra coverage for future dental expenses.

Rollover Examples

Below are examples showing how rollover amounts can accumulate—or reset—based on your annual usage.

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

- Year 2 shows no rollover because claims exceeded 50% of the maximum.
- Year 4 resets to $0 because preventive care was not completed or no claims were submitted.
- This is why it *pays to visit your dentist regularly for preventive care*.

Principal Dental Out-Of-Network Charges

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

However, if you choose to go to an out-of-network Dentist, your procedure could still be covered at the prevailing fee set by Principal Dental. The prevailing fee is the maximum dollar amount reimbursed for each service and is based on the 99th percentile of what dentists charge within a defined geographic region (by ZIP code.)

Example:

Let's look at how a particular dental procedure might be paid depending on whether your dentist is in-network or out-of-network. The standard charge for your procedure in both cases is $985.

If Your Dentist Is **In-Network**

- Maximum allowed amount (per contract with Principal): $650
- Principal pays 80%: $520
- Your coinsurance (20%): $130
- Your total out-of-pocket cost: $130

You pay only your coinsurance. In-network dentists agree not to bill you for the difference.

If Your Dentist Is **Out-of-Network**

- Prevailing fee used by Principal: $830
- Principal pays 80% of prevailing fee: $664
- Your coinsurance (20%): $166
- Possible balance bill: $155 ($985 original charge minus payments from you and Principal)

Because out-of-network dentists are not bound by a fee agreement, they can bill you for the difference between their charge and the amount Principal covers so your total potential cost is $321 ($166 coinsurance + $155 balance bill)

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, or 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, or 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.

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.

County-Paid Coverage - $50,000

Miami County provides a $50,000 Life and Accidental Death and Dismemberment ("AD&D") policy 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

You may elect or increase voluntary life and AD&D insurance coverage for yourself, your spouse, and your child(ren) either **as a new hire** or **during open enrollment**. If elected after new hire enrollment, an EOI may be required.

Child Policies

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
DEDUCTION	$0.21	$0.42	$0.63	$0.84

Employee & Spouse Guarantee Issue & Maximum Amounts

Guarantee Issue (GI) amounts, marked with an asterisk (*), represent the maximum coverage you can elect without completing an Evidence of Insurability (EOI) form **during your initial new hire enrollment**. If you request an amount higher than the GI limit, you'll receive detailed instructions from Mutual of Omaha.

Employee Incremental Amount	$10,000	Spouse Incremental Amount	$5,000
Employee Guarantee Issue *	$100,000	Spouse Guarantee Issue *	Up to $25,000
Employee Maximum Amount	$230,000	Spouse Maximum Amount	$200,000
Reduction Schedule	Age 65 – 35% * Age 70 – 60% * Age 75 – 75% * Age 80 – 85%		

As a New Hire

Employee Coverage

- You may elect up to $100,000 in additional coverage without completing an Evidence of Insurability (EOI). **(new hire only)**
- You may elect more than $100,000 and up to $230,000 with an approved EOI.

Spouse Coverage

- Spouse coverage cannot exceed 50% of your elected employee coverage.
- You may elect up to $25,000 for your spouse without an EOI. **(during new hire only)**
- You may elect more than $25,000 and up to $200,000 with an approved EOI.

Child(ren) Coverage

- You may elect up to $10,000 for your eligible child(ren) without an EOI.

During Open Enrollment

Employee Coverage

- You may increase your existing coverage by $10,000 per year, up to the $100,000 limit, without an EOI.
- Increases that bring your total above $100,000 (up to $230,000) require an approved EOI.

Spouse Coverage

- Spouse coverage cannot exceed 50% of your total employee coverage.
- Increases that bring your spouse's total above $25,000 (up to $200,000) require an approved EOI.

Rates

AD&D coverage, regardless of age, is $0.01 per month per $1,000 of coverage elected.

Life insurance rates are shown on the table below. 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, 2026. Divide the amount of life insurance you are requesting by $1,000 and multiply this number by the rate for the appropriate 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

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

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 of $46.05 per check.

ASSURITY SUPPLEMENTAL PLANS

PLEASE NOTE: If you were enrolled in an Aflac plan in 2025, your coverage will end on December 31, 2025.

Effective January 1, 2026, Miami County will offer five supplemental insurance plans through a partnership with Assurity, as listed below. All plan details and rates are explained in detail with individual brochures in UKG.

Please refer to the plan documents for full details, pricing, limitations, conditions and exclusions.

For questions about plans and claims, contact:
Susan Svarda
PH: 937.730.0067
ssvarda@voluntarypartners.com

Accident

Even with a good health insurance plan, a trip to the doctor or hospital can be expensive. Many people find themselves paying more out of their own pocket each year. If you or someone in your family are hurt in an accident, the last thing you want to think about is how you are going to pay for medical care.

Accident expense insurance provides peace of mind and gives you additional cash to help pay your health insurance deductible and other expenses.

Group Accident Expense insurance pays a benefit directly to you when you receive treatment from a physician for a covered accident.

Accident (Biweekly)	All Ages
Employee	$6.97
Employee + Spouse	$12.18
Employee + Child(ren)	$14.51
Family	$21.45

Key Features

- Helps with out-of-pocket expenses associated with covered accidents
- No deductibles, copays, coinsurance or networks - see any doctor
- Guaranteed issue – no medical exams or tests
- Portable – coverage continues if you retire or change jobs, as long as you pay the premiums

Hospital Indemnity

A hospital stay can be expensive - even with a good health insurance plan. If you or someone in your family gets sick or injured and needs to go to the hospital, the last thing you want to think about is how you are going to pay for medical care.

Hospital indemnity insurance provides peace of mind and gives you additional cash to pay your health insurance deductible and other expenses resulting from a covered hospital stay.

Group Hospital Indemnity insurance pays a benefit directly to you, starting at admission, for each day of hospital confinement.

Hospital (Biweekly)	All Ages
Employee	$9.11
Employee + Spouse	$18.79
Employee + Child(ren)	$17.10
Family	$26.78

Key Features

- Pays a lump-sum benefit starting at admission
- No deductibles, copays, coinsurance or networks (see any doctor)
- Guaranteed issue – no medical exams or tests
- Portable – coverage continues if you retire or change jobs, as long as you pay the premiums

Critical Illness

More people are surviving life threatening illnesses than ever before. Unfortunately, the cost of critical illness care is high and medical bills can follow survivors long after they've proven victorious in their fight.

Critical illness insurance provides peace of mind and gives you additional cash to help pay your health insurance deductible and other out-of-pocket expenses.

Group Critical Illness insurance pays a lump-sum benefit directly to you if you are diagnosed with stroke, heart attack or a number of other covered

Key Features

- Pays a lump sum directly to you
- Includes a health screening benefit which pays $50 a year for any number of common covered medical tests or procedures
- Guaranteed issue – no medical exams or tests
- Portable – coverage continues if you retire or change jobs, as long as you pay the premiums

CI: Employee or Employee & Child(ren) (Biweekly)			
	Benefit Amount		
Issue Age	$10,000	$20,000	$30,000
18-24	$2.06	$3.55	$5.03
25-29	$2.76	$4.77	$6.80
30-34	$3.61	$6.39	$9.15
35-39	$5.20	$9.27	$13.32
40-44	$7.07	$12.69	$18.29
45-49	$9.71	$17.82	$25.91
50-54	$13.53	$25.25	$36.96
55-59	$18.70	$35.50	$52.28
60-64	$23.36	$44.97	$66.57
65-69	$30.64	$59.62	$88.61
70+	$45.16	$88.56	$131.93

CI: Employee & Spouse or Family (Biweekly)			
	Benefit Amount		
Issue Age	$10,000	$20,000	$30,000
18-24	$3.28	$5.47	$7.66
25-29	$4.33	$7.29	$10.26
30-34	$5.69	$9.77	$13.85
35-39	$8.21	$14.23	$20.26
40-44	$11.15	$19.52	$27.87
45-49	$15.26	$27.35	$39.45
50-54	$21.10	$38.65	$56.18
55-59	$28.96	$54.12	$79.29
60-64	$35.89	$68.29	$100.68
65-69	$46.79	$90.26	$133.73
70+	$68.63	$133.71	$198.79

Short Term Disability

An accident or injury may stop you from working, but it won't stop your bills. If you're unable to work, do you have enough money set aside to cover your expenses while you recover?

Disability Income insurance helps replace income and maintain financial stability if you become disabled and are unable to work, providing a reliable stream of income and peace of mind.

Group Short-Term Disability Income insurance pays a weekly benefit directly to you if you are sick or injured and can't work.

Key Features

- Pays benefits if you become totally disabled and can't perform the important duties of your occupation, as long as you are not working another job and are under the care of a physician
- Weekly benefit from $250 to $1,000 by $50 increments, subject to maximum benefit of 60% of weekly income
- Pays 50% of your weekly total disability benefit if you return to work part time, following a period of paid total disability

Short Term Disability (Biweekly)								
Annual Income	**$21,750**	**$26,000**	**$30,500**	**$34,750**	**$39,000**	**$43,500**	**$47,750**	**$52,000**
Weekly Benefit	**$250**	**$300**	**$350**	**$400**	**$450**	**$500**	**$550**	**$600**
Issue Age								
18-49	$14.87	$17.85	$20.83	$23.80	$26.78	$29.76	$32.72	$35.70
50-59	$22.42	$26.90	$31.39	$35.86	$40.36	$44.83	$49.33	$53.80
60-69	$31.73	$38.09	$44.43	$50.78	$57.13	$63.48	$69.82	$76.16
70+	$44.61	$53.53	$62.46	$71.39	$80.31	$89.24	$98.15	$107.06

Short Term Disability (Biweekly)								
Annual Income	**$56,500**	**$60,750**	**$65,000**	**$69,500**	**$73,750**	**$78,000**	**$82,500**	**$86,750**
Weekly Benefit	**$650**	**$700**	**$750**	**$800**	**$850**	**$900**	**$950**	**$1,000**
Issue Age								
18-49	$38.68	$41.65	$44.63	$47.61	$50.58	$53.55	$56.54	$59.51
50-59	$58.29	$62.78	$67.26	$71.75	$76.23	$80.71	$85.20	$89.68
60-69	$82.50	$88.86	$95.20	$101.56	$107.90	$114.25	$120.60	$126.95
70+	$115.99	$124.92	$133.84	$142.76	$151.69	$160.62	$169.54	$178.45

Term Life Insurance

Term life insurance is designed as an inexpensive solution to short-term insurance needs. As the name implies, this coverage lasts for a specified period of time, often when a family is most vulnerable to losing income if something happens to the insured.

Key Features:

- Easy-to-understand life coverage for shorter-term or specific needs
- Guaranteed, level premium periods
- Affordable coverage through payroll deduction
- Coverage is available for you, your spouse and children
- Excellent option to supplement permanent life benefits
- Coverage may be converted to permanent life insurance
- Portable coverage—if you switch jobs or retire you can take your coverage with you, after 30 days of continuous coverage

NOTE: Guaranteed issue benefit maximum is $150,000 for ages 18-60 and $75,000 for issue ages 61 and above. Benefit amounts above those limits are subject to underwriting.

10-YEAR TERM PRICING

Employee-Only, 10-Year Level Premium, Blended (Biweekly)							
	Employee Benefit Amt.	**$25,000**	**$50,000**	**$75,000**	**$100,000**	**$125,000**	**$150,000**
Employee Age	Under 26	$1.63	$3.27	$4.90	$6.54	$8.17	$9.81
	26-30	$1.82	$3.64	$5.46	$7.29	$9.11	$10.93
	31-35	$2.69	$5.39	$8.09	$10.79	$13.48	$16.18
	36-40	$3.82	$7.64	$11.46	$15.29	$19.11	$22.93
	41-45	$4.80	$9.60	$14.40	$19.20	$24.00	$28.81
	46-50	$6.49	$12.99	$19.49	$25.99	$32.49	$38.99
	51-55	$9.69	$19.39	$29.09	$38.79	$48.48	$58.18
	56-60	$14.78	$29.56	$44.34	$59.12	$73.90	$88.68
	61-65	$23.30	$46.60	$69.90	n/a	n/a	n/a
	66-70	$37.31	$74.62	$111.93	n/a	n/a	n/a
Employee & Spouse, 10-Year Level Premium, Blended (Biweekly)							
	Employee Benefit Amt.	**$25,000**	**$50,000**	**$75,000**	**$100,000**	**$125,000**	**$150,000**
	Spouse Benefit Amt.	**$7,500**	**$15,000**	**$22,500**	**$30,000**	**$37,500**	**$45,000**
Employee Age	Under 26	$2.27	$4.56	$6.84	$9.13	$11.41	$13.70
	26-30	$2.51	$5.03	$7.55	$10.07	$12.59	$15.11
	31-35	$3.69	$7.40	$11.10	$14.81	$18.51	$22.21
	36-40	$5.24	$10.48	$15.73	$20.98	$26.23	$31.47
	41-45	$6.59	$13.19	$19.79	$26.38	$32.98	$39.59
	46-50	$8.90	$17.82	$26.73	$35.65	$44.56	$53.48
	51-55	$13.27	$26.56	$39.85	$53.13	$66.41	$79.70
	56-60	$20.23	$40.47	$60.71	$80.95	$101.19	$121.43
	61-65	$31.93	$63.87	$95.81	n/a	n/a	n/a
	66-70	$51.19	$102.38	$153.58	n/a	n/a	n/a
Employee & Child, 10-Year Level Premium, Blended (Biweekly)							
	Employee Benefit Amt.	**$25,000**	**$50,000**	**$75,000**	**$100,000**	**$125,000**	**$150,000**
	Children Benefit Amt.	**$2,500**	**$5,000**	**$7,500**	**$10,000**	**$12,500**	**$15,000**
Employee Age	Under 26	$2.14	$4.30	$6.44	$8.60	$10.74	$12.90
	26-30	$2.33	$4.67	$7.00	$9.35	$11.68	$14.02
	31-35	$3.20	$6.42	$9.63	$12.85	$16.05	$19.27
	36-40	$4.33	$8.67	$13.00	$17.35	$21.68	$26.02
	41-45	$5.31	$10.63	$15.94	$21.26	$26.57	$31.90
	46-50	$7.00	$14.02	$21.03	$28.05	$35.06	$42.08
	51-55	$10.20	$20.42	$30.63	$40.85	$51.05	$61.27
	56-60	$15.29	$30.59	$45.88	$61.18	$76.47	$91.77
	61-65	$23.81	$47.63	$71.44	n/a	n/a	n/a
	66-70	$37.82	$75.65	$113.47	n/a	n/a	n/a
Family, 10-Year Level Premium, Blended (Biweekly)							
	Employee Benefit Amt.	**$25,000**	**$50,000**	**$75,000**	**$100,000**	**$125,000**	**$150,000**
	Spouse Benefit Amt.	**$7,500**	**$15,000**	**$22,500**	**$30,000**	**$37,500**	**$45,000**
	Children Benefit Amt.	**$2,500**	**$5,000**	**$7,500**	**$10,000**	**$12,500**	**$15,000**
Employee Age	Under 26	$2.78	$5.59	$8.38	$11.19	$13.98	$16.79
	26-30	$3.02	$6.06	$9.09	$12.13	$15.16	$18.20
	31-35	$4.20	$8.43	$12.64	$16.87	$21.08	$25.30
	36-40	$5.75	$11.51	$17.27	$23.04	$28.80	$34.56
	41-45	$7.10	$14.22	$21.33	$28.44	$35.55	$42.68
	46-50	$9.41	$18.85	$28.27	$37.71	$47.13	$56.57
	51-55	$13.78	$27.59	$41.39	$55.19	$68.98	$82.79
	56-60	$20.74	$41.50	$62.25	$83.01	$103.76	$124.52
	61-65	$32.44	$64.90	$97.35	n/a	n/a	n/a
	66-70	$51.70	$103.41	$155.12	n/a	n/a	n/a

Fields showing n/a represents combinations of issue age and benefit amount outside allowable issue limits.

20-YEAR TERM PRICING

Employee-Only, 20-Year Level Premium, Blended (Biweekly)							
	Employee Benefit Amt.	**$25,000**	**$50,000**	**$75,000**	**$100,000**	**$125,000**	**$150,000**
Employee Age	Under 26	$1.66	$3.33	$4.99	$6.66	$8.33	$9.99
	26-30	$1.97	$3.95	$5.93	$7.91	$9.89	$11.87
	31-35	$2.81	$5.62	$8.43	$11.24	$14.06	$16.87
	36-40	$3.95	$7.91	$11.87	$15.83	$19.79	$23.74
	41-45	$5.17	$10.35	$15.53	$20.70	$25.88	$31.06
	46-50	$7.21	$14.43	$21.65	$28.87	$36.09	$43.31
	51-55	$10.89	$21.79	$32.68	$43.58	$54.47	$65.37
	56-60	$16.71	$33.43	$50.15	$66.87	$83.59	$100.30
Employee & Spouse, 20-Year Level Premium, Blended (Biweekly)							
	Employee Benefit Amt.	**$25,000**	**$50,000**	**$75,000**	**$100,000**	**$125,000**	**$150,000**
	Spouse Benefit Amt.	**$7,500**	**$15,000**	**$22,500**	**$30,000**	**$37,500**	**$45,000**
Employee Age	Under 26	$2.31	$4.64	$6.95	$9.28	$11.61	$13.92
	26-30	$2.72	$5.45	$8.18	$10.92	$13.65	$16.38
	31-35	$3.86	$7.72	$11.58	$15.45	$19.32	$23.18
	36-40	$5.42	$10.85	$16.29	$21.72	$27.16	$32.58
	41-45	$7.10	$14.21	$21.32	$28.42	$35.53	$42.64
	46-50	$9.89	$19.79	$29.69	$39.59	$49.49	$59.39
	51-55	$14.91	$29.84	$44.76	$59.69	$74.60	$89.53
	56-60	$22.88	$45.77	$68.67	$91.56	$114.46	$137.34
Employee & Child, 20-Year Level Premium, Blended (Biweekly)							
	Employee Benefit Amt.	**$25,000**	**$50,000**	**$75,000**	**$100,000**	**$125,000**	**$150,000**
	Children Benefit Amt.	**$2,500**	**$5,000**	**$7,500**	**$10,000**	**$12,500**	**$15,000**
Employee Age	Under 26	$2.17	$4.36	$6.53	$8.72	$10.90	$13.08
	26-30	$2.48	$4.98	$7.47	$9.97	$12.46	$14.96
	31-35	$3.32	$6.65	$9.97	$13.30	$16.63	$19.96
	36-40	$4.46	$8.94	$13.41	$17.89	$22.36	$26.83
	41-45	$5.68	$11.38	$17.07	$22.76	$28.45	$34.15
	46-50	$7.72	$15.46	$23.19	$30.93	$38.66	$46.40
	51-55	$11.40	$22.82	$34.22	$45.64	$57.04	$68.46
	56-60	$17.22	$34.46	$51.69	$68.93	$86.16	$103.39
Family, 20-Year Level Premium, Blended (Biweekly)							
	Employee Benefit Amt.	**$25,000**	**$50,000**	**$75,000**	**$100,000**	**$125,000**	**$150,000**
	Spouse Benefit Amt.	**$7,500**	**$15,000**	**$22,500**	**$30,000**	**$37,500**	**$45,000**
	Children Benefit Amt.	**$2,500**	**$5,000**	**$7,500**	**$10,000**	**$12,500**	**$15,000**
Employee Age	Under 26	$2.82	$5.67	$8.49	$11.34	$14.18	$17.01
	26-30	$3.23	$6.48	$9.72	$12.98	$16.22	$19.47
	31-35	$4.37	$8.75	$13.12	$17.51	$21.89	$26.27
	36-40	$5.93	$11.88	$17.83	$23.78	$29.73	$35.67
	41-45	$7.61	$15.24	$22.86	$30.48	$38.10	$45.73
	46-50	$10.40	$20.82	$31.23	$41.65	$52.06	$62.48
	51-55	$15.42	$30.87	$46.30	$61.75	$77.17	$92.62
	56-60	$23.39	$46.80	$70.21	$93.62	$117.03	$140.43

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

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

Member Handbook

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.

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.

Retiring from Public Employment

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.

Traditional | Member Directed | Combined

Returning to Work

Returning to Work After Retirement

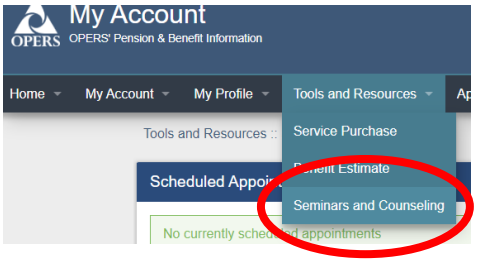
Once you retire under any of the OPERS retirement plans, re-employment in a job that is covered by OPERS, including service in an elected position, may affect continuing receipt of benefits. Retirees who become re-employed must notify the employer that they are receiving an OPERS retirement benefit.

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(b) 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.

Miami County began offering a Roth option under the Ohio Deferred Compensation plan in 2025.

Employees have the option to choose from two vendors, 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)
Jim Carberry, Retirement Plan Advisor
513.516.4285 | jim.carberry@empower.com
https://jim-carberry.empowermytime.com

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. For more information, visit www.medicare.gov or call 1-800-633-4227.

Miami County's insurance broker, Benefits Analysis Corporation, is available to assist you with the Medicare process. Contact 937-335-5751 to schedule a personalized, one-on-one session.

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.

FITNESS CENTER DISCOUNTS

Effective January 1, 2026, Miami County will no longer cover the cost of Lincoln Community Center memberships.

Miami County YMCA

All Miami County employees and their families receive a **30% discount off monthly membership fees** with the Miami County YMCA. Employees who do not use their membership for three consecutive months will lose their membership discount.

The Miami County YMCA has two conveniently located branches:

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

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

Membership includes:
Unlimited access to both branches, open gym, free child watch, family fun nights, open swim for adults & families, program guides, member classes, program rates, 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	$53.50	$36.01
Senior Couple	$53.50	$32.49
Family	$53.50	$43.82
Health Center Memberships:		
Single Adult	No additional enrollment fee	$32.19
Senior Adult		$28.98
Couple		$41.46
Senior Couple		$37.27

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

Anytime Fitness

All Miami County employees and one family member can join Anytime Fitness Troy for $1.00 down and $20 off their monthly membership plan.

Along with your membership, you will receive a customized Fitness program based on your Goals, Nutritional Seminar with guidance from our Team, along with an Accountability Coach to keep you on your path of success.

To sign up, call 937.339.3030 to set up an appointment or stop in Monday – Friday 9a – 7p or Saturday 9a-12p. Please bring an employee ID or check stub to verify employment with Miami County.

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.

ANNUAL NOTICES

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 in this benefit guide apply. If you would like more information on WCHRA benefits, call your plan administrator at (937) 440-5996.

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.govto 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

Your summary of benefits

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: 1/1/2026**

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: 1/1/2026**

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.

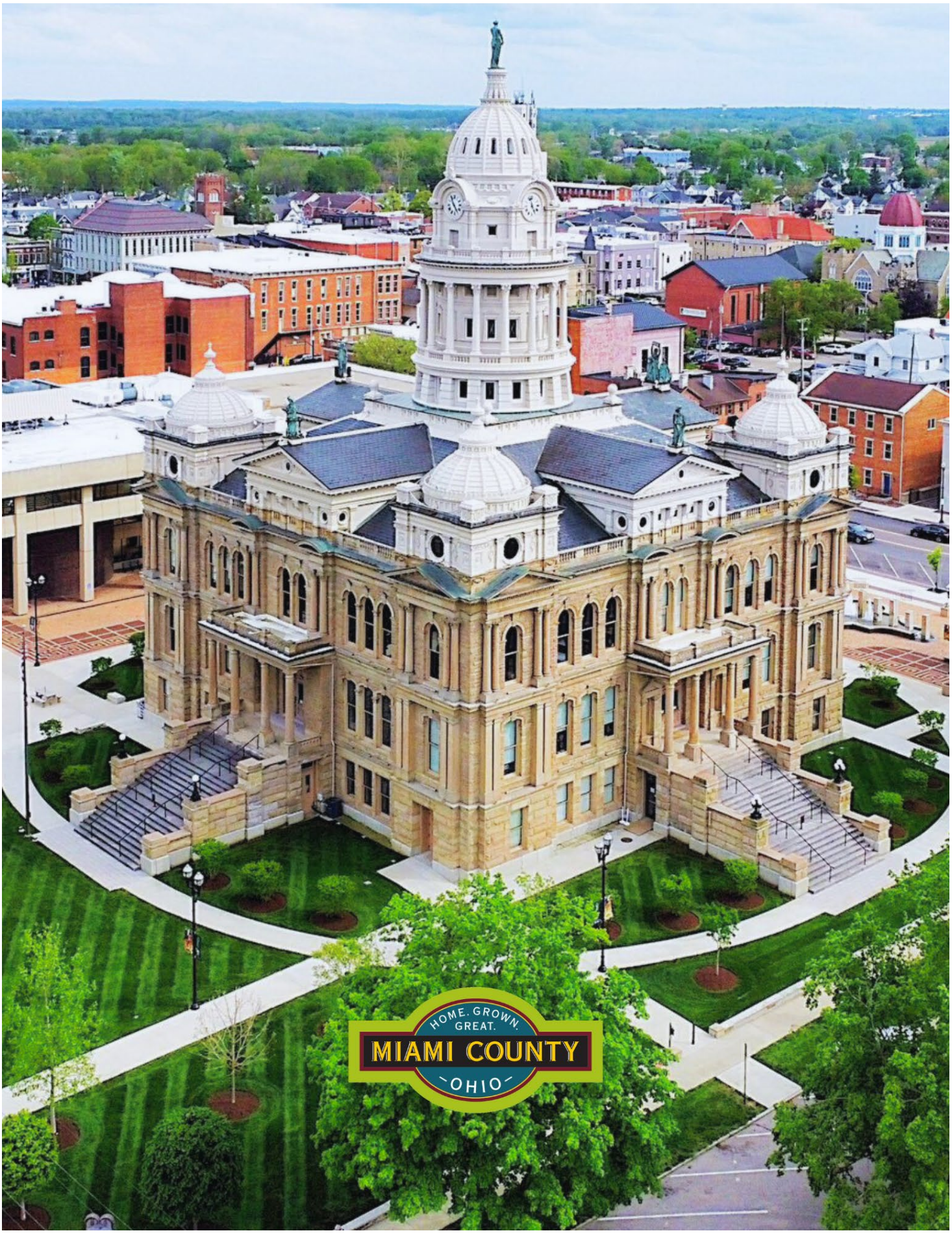
Questions: (833) 639-1634 or visit us at www.anthem.com

2026 PAYROLL CALENDAR

PAY PERIOD			PAY DATE
12/20/2025	-	1/2/2026	1/9/2026
1/3/2026	-	1/16/2026	1/23/2026
1/17/2026	-	1/30/2026	2/6/2026
1/31/2026	-	2/13/2026	2/20/2026
2/14/2026	-	2/27/2026	3/6/2026
2/28/2026	-	3/13/2026	3/20/2026
3/14/2026	-	3/27/2026	4/3/2026
3/28/2026	-	4/10/2026	4/17/2026
4/11/2026	-	4/24/2026	5/1/2026
4/25/2026	-	5/8/2026	5/15/2026
5/9/2026	-	5/22/2026	5/29/2026
5/23/2026	-	6/5/2026	6/12/2026
6/6/2026	-	6/19/2026	6/26/2026
6/20/2026	-	7/3/2026	7/10/2026
7/4/2026	-	7/17/2026	7/24/2026
7/18/2026	-	7/31/2026	8/7/2026
8/1/2026	-	8/14/2026	8/21/2026
8/15/2026	-	8/28/2026	9/4/2026
8/29/2026	-	9/11/2026	9/18/2026
9/12/2026	-	9/25/2026	10/2/2026
9/26/2026	-	10/9/2026	10/16/2026
10/10/2026	-	10/23/2026	10/30/2026
10/24/2026	-	11/6/2026	11/13/2026
11/7/2026	-	11/20/2026	11/27/2026
11/21/2026	-	12/4/2026	12/11/2026
12/5/2026	-	12/18/2026	12/25/2026

notes

notes


HOME. GROWN.
GREAT.
MIAMI COUNTY
OHIO