LUCAS COUNTY

Today. Tomorrow. Together.

2026 EMPLOYEE BENEFITS GUIDE

Plan Year 3/1/2026 - 2/28/2027

Benefits designed for you!

Scan here to view your Digital 2026 Benefits Guide!

Table of Contents

This booklet is intended as a high-level overview and is for informational purposes only. The plan documents, contribution schedules, insurance certificates and policies will serve as the governing documents to determine plan eligibility, benefits and payments. In the case of conflict between the information in this booklet and the official plan documents, the plan documents will always govern.

We are here to help you with your benefit questions, claim issues, and general inquiries.

Employee Benefits

(419) 213-4189

employeebenefits@co.lucas.oh.us

www.co.lucas.oh.us/235/Employee-BenefitsWellness

Questions About	Carrier	Phone	Website
Medical	Anthem BCBS	(833) 952-2024 Ask to "Speak to Representative"	www.anthem.com
Prescription Drug	Anthem BCBS/Carelon	(833) 421-4717 Ask to "Speak to Representative"	www.anthem.com
Vision - Blue View Vision	Anthem BCBS	(866) 723-0515 Press '0' for LIVE person	www.anthem.com
Dental	Delta Dental	(800) 524-0149	www.deltadentaloh.com
Basic Life and AD&D	MetLife	(800) 638-5433	www.metlife.com
Medical FSA Dependent Care FSA	Health Equity	(877) 924-3967	participant.wageworks.com
Short Term Disability (STD) Long Term Disability (LTD) Vol. Term Life & AD&D	MetLife	(800) 638-5433	www.metlife.com
Accident, Critical Illness, and Hospital Indemnity	Aflac	(800) 433-3036	www.aflacgroupinsurance.com
Life Term to 120	Aflac	(800) 433-3036	www.aflacgroupinsurance.com
ID Theft Legal Assistance	MetLife	(800) 638-5433	www.metlife.com
Pet Insurance	Trupanion / Aflac	(877) 232-4605	https://www.aflac.com/individuals/products/pet-insurance.aspx
Lucas County Benefits	Employee Benefits	(419) 213-4189	www.co.lucas.oh.us/235/Employee-BenefitsWellness
Enrollment Support	Steele Benefits	(574) 821-6022	www.aflacatwork.com/lucascounty
Employee Assistance Program (EAP)	Lighthouse EAP	(419) 475-5338	www.harbor.org/services/employee-assistance-program

At a Glance: 2026 Highlights

The Board of Lucas County Commissioners is proud to continue offering a competitive and comprehensive benefits package to employees and their dependents for the 2026 plan year.

This is NOT a mandatory re-enrollment year. We encourage all employees to review their current benefit elections, but only employees who wish to make changes are required to log in.

There is one exception: If you are enrolled in a medical FSA or dependent care account, you must make an election each year to continue the benefit.

All changes made during open enrollment are effective March 1, 2026 - February 28, 2027.

Open Enrollment will run Monday, January 12 through Wednesday, January 28.

Know Before You Enroll: Virtual Open Enrollment Meetings
Wednesday, January 7 @ 9am
Wednesday, January 14 @ 9am
Wednesday, January 21 @ 9am
Wednesday, January 28 @ 9am

Effective March 1, 2026

- There will be an increase in employee premium contribution to the single and family medical/prescription plans, significantly below the national average of 9%. Lucas County contributes 95% of the total cost share. There will continue to be no additional employee cost to enroll in dental, vision, or basic life insurance plans.

	MONTHLY CONTRIBUTIONS		
	Single	Family	Family – Spouse Primary
Medical/Prescription - Pre-Tax			
Non-Deductible Plan	$75.00	$125.00	$400.00
Deductible Plan	$35.00	$75.00	$400.00

- The IRS has increased the Medical FSA annual election to $3,400 (up from $3,300) and the carryover amount to $680 (up from $660). Please note: The IRS requires that FSA funds must be used within the plan year elected. However, carryover funds can extend beyond the end of the plan year. Unused funds at the end of the plan year are forfeited.

At a Glance: 2026 Highlights

- The One Big Beautiful Bill Act provided expanded Dependent Care Flexible Spending Account limits. The limit increases from $5,000 to $7,500 for single individuals and married couples filing jointly, and $3,750 for married individuals filing separately.

- Ohio House Bill 315A Madeline's Law- This law requires health benefit plans to provide coverage for the full cost of medically appropriate hearing aids, up to $2,500 per hearing aid, allowed every 48 months for those 21 years of age or younger.

- Ohio House Bill 315B Occupational Therapy, Physical Therapy, Chiropractic Cost Share- This bill requires a health benefit plan to apply, the same cost sharing requirements for professional occupational therapy, physical therapy, and chiropractic services as the cost sharing requirement for an office visit to a primary care physician.

- Expanded preventive breast cancer screening coverage including additional imaging services (e.g., ultrasounds or MRIs) when medically indicated, and pathology services (e.g., a needle biopsy), if necessary to complete screening process for malignancies or address findings on the initial mammography.

- Employee Benefits is no longer required to print and mail employee's 1095-C tax forms. Forms are available upon request employeebenefits@co.lucas.oh.us.

- As part of your health plan benefits, you have the right to review a Summary of Benefits and Coverage (SBC), which explains your coverage options in clear, easy to understand terms. You can access the Summary of Benefits and Coverage (SBC) for your plan at: https://co.lucas.oh.us/236/MedicalPrescription-Drug-Insurance

Your benefits are an important part of your total compensation at Lucas County. Through our benefits programs we strive to support the needs of our employees and their dependents by providing a benefits package that is easy to understand, easy to access, and affordable for all our employees.

Please take the time to review this Benefits Guide to assist you in making informed enrollment decisions that are the best fit for the health, wellness and financial needs of you and your family.

The benefits outlined in this document are effective: March 1, 2026, through February 28, 2027.

Enrolling in Benefits

Open Enrollment: January 12 - 28

1. **By Phone: (574) 821-6022**
   Certified Benefit Counselors | Monday – Friday | 8:30am – 5pm

2. **Self-Enrollment through our Online Enrollment System**
   https://aflacatwork.com/lucascounty

3. **Sign up to meet with an enrollment specialist VIRTUALLY (during open enrollment only), please click the link below.**

   https://outlook.office.com/book/LucasCounty@steelebenefits.com/?ismsaljsauthenabled

4. **Sign up to meet with an enrollment specialist ON-SITE (during open enrollment only), please click the link below.**

   https://outlook.office.com/book/LucasCounty@steelebenefits.com/?ismsaljsauthenabled

This Benefits Guide provides an overview of your benefit options and additional information to help you make your enrollment decisions. Additional reference materials are available electronically on the benefits website at www.co.lucas.oh.us/235/Employee-BenefitsWellness

This is NOT a mandatory re-enrollment year. We encourage all employees to review their current benefit elections, but only employees who wish to make changes are required to log in.
There is one exception: If you are enrolled in a medical FSA or dependent care account, you must make an election each year to continue the benefit.

We have partnered with Steele Benefits to provide enrollment support. Through this partnership we also utilize a communication tool that allows us to share important benefit updates and deadline reminders with employees via text and email.

Email will remain our primary means of communication. When enrolling, please provide an email where you would like to receive important benefit information. Open enrollment is a great time to review this email and update if needed.

In addition, you can opt in/opt out of text communications.

Choose your benefits wisely! After the enrollment deadline, benefit elections cannot be changed or canceled until the next enrollment period unless a qualifying event occurs.

Benefits Eligibility

As a benefits-eligible employee, Lucas County offers you a benefits program that provides you and your family coverage that helps reduce your medical expenses, improve your health and well-being, and protect you while you are an active employee.

When Does Coverage Begin?

All open enrollment changes are effective March 1, 2026. Newly hired full-time employees and dependents will be effective on the 31st day of employment for all benefits except flexible spending accounts and voluntary insurance plans. Those are effective from the 1st of the month after you become eligible. All elections are in effect for the entire plan year and can only be changed during open enrollment unless you experience a qualifying life event. All qualifying life events must be completed within 30 days of the date of the event.

Dependent Eligibility:

Your dependents may also be covered under the benefit plans described below.

Benefit	Legal Spouse	Dependent Child(ren)
Medical/ Rx	√	Up to age 26
Dental & Vision	√	Up to age 26
Basic Life	√	Up to age 26
Voluntary Life and AD&D	√	Up to age 26

Dependent Verification:

You may be asked to provide proof of dependent eligibility, which may include one or more of the following:

- Marriage Certificate
- Birth Certificate
- Affidavit of Qualifying Adult
- Adoption Certificate
- Placement Certificate
- Document of Guardianship
- Other as necessary

When Does Coverage End?

If employment is terminated medical, prescription drug, vision, dental, and basic life insurance coverage ends at the end of the month in which you terminate employment. All flexible spending accounts and voluntary insurance plans end as of the date of termination.

To continue your coverage with Aflac, visit www.aflacgroupinsurance.com, complete the Continuation of Coverage Form, and submit it within 31 days of your termination date.

MetLife's basic and voluntary term life and AD&D, legal & identity fraud protection plans are portable. Contact Employee Benefits if you are interested in continuing these plans.

Dependent's coverage will be terminated at the end of the month in which they turn 26.

COBRA- Continuation of Coverage

When you or any of your dependents no longer meet the eligibility requirements under this plan, you may be eligible for continued coverage as required by the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985. Please contact Employee Benefits for COBRA rates.

Making Changes During the Year

Unless you experience a qualifying life event, you cannot make changes to your benefits until the next open enrollment period. You must notify Employee Benefits of such change(s) within the noted days from the event as shown in the below table. Failure to notify Employee Benefits within the timeframe (and provide any necessary dependent documentation) will require you to wait until the next open enrollment period to make your change. Qualifying events may require documentation such as marriage certificate, birth certificate, divorce decree, etc. to finalize the event change. For questions, please contact Employee Benefits.

Qualifying Event	Timeframe to Notify Employee Benefits*
Marriage, divorce or legal separation	30 days
Birth, adoption or placement for adoption	30 days
Death of a dependent	30 days
Change in your spouse's employment status	30 days
Change in coverage status under your spouse's plan	30 days
A gain/loss of eligibility for other health coverage for a spouse/dependent	30 days
Change in dependent child's status, either newly satisfying the requirements for dependent child status or ceasing to satisfy them	30 days
Judgment, decree or court order allowing you to add or drop coverage for a dependent child	30 days
Change in eligibility for Medicare or Medicaid	60 days

**days from the qualifying event*

Turning 65 and Becoming Medicare Eligible

If you are an active employee and have reached the age of 65, you may be wondering about Medicare. If you are already receiving Social Security benefits, you should receive an advisory notice from Medicare about three (3) months before your 65th birthday for your initial enrollment period. Otherwise, you have the option to enroll in Medicare yourself by contacting your local Social Security office; however, you are not required to enroll in Medicare until loss of active coverage.

For additional information on Medicare eligibility and enrollment periods, please visit **www.Medicare.gov**. You may also reach out to the Hylant Medicare Advisory Center at (885) 574-8822 or via email at **MedicareAdvisoryCenter@hylant.com**.

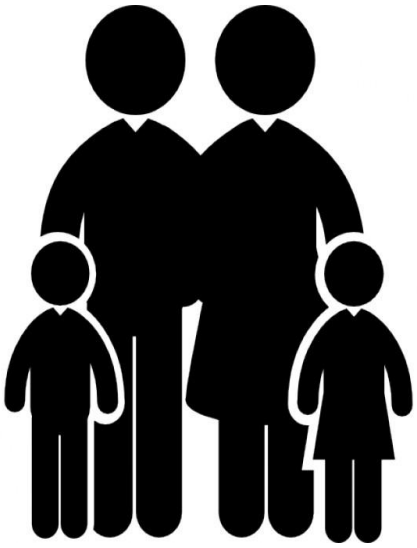
Beneficiary Designation

In addition to electing or making benefit changes during open enrollment, it is important to designate a beneficiary for your life insurance. Your beneficiary is the person(s) who will receive your life insurance benefits when you die. If you have a beneficiary in place, or if your family situation has changed, now is the time to ensure all information on record is correct. If you do not name a beneficiary, your benefits will automatically be disbursed per the terms of the Certificate of Coverage.

Spousal Eligibility

No changes in family-spouse primary premium or spousal eligibility for plan year 2026.

Family-Spouse Primary coverage option for Medical/Prescription Drug Coverage



Family-Spouse Primary

$400 per month

If you are covering a spouse who does not have access to other primary insurance, you will choose the Family-Spouse Primary coverage option for either of the 2 Medical/Prescription Drug plans.

You can enroll in either Single or Family coverage for Vision and Dental for no additional cost.

***2 Married County Employees- You will NOT enroll in Family-Spouse Primary Coverage for $400 per month. You can either enroll in 2 single plans, or one employee will enroll in FAMILY, one will waive Medical/Prescription Drug Coverage**

Here's how adding a spouse as primary works:

- Spouses with coverage through the federal Marketplace who receive tax credits or subsidies are not eligible for those discounts because Lucas County offers primary medical coverage for spouses.
- Spouses eligible for medical and prescription drug coverage through an employer have a choice to continue primary coverage through their employer and enroll in secondary coverage with the County and pay the family medical/prescription drug plan deduction or enroll in the family spouse primary medical/prescription drug plan with the County for $400/month.
- Spouses who are eligible for medical and prescription drug coverage under any other government plan (Medicare, Medicaid, Tricare, etc.) can choose to be primary on the Government Plan's medical plan or choose to enroll in the family spouse primary medical/prescription drug plan with the County for $400/month.
- Spouses eligible for medical and prescription drug coverage through a former employer as a retiree, must enroll as primary in any medical coverage sponsored by his/her former employer for their retirees, regardless of any required premium, and can enroll in secondary coverage with the County and pay the family medical/prescription drug plan deduction. Spouses who do not have access to medical coverage through his/her former employer as a retiree but receive a stipend, please check with retirement plan, including OPERS if they allow you to use stipend on employer premiums.

Employee Cost of Coverage

	Monthly Contributions		
	Single	Family	Family - Spouse Primary
Medical/Prescription - Pre-Tax			
Non-Deductible Plan	$75.00	$125.00	$400.00
Deductible Plan	$35.00	$75.00	$400.00

Dental	100% Employer Paid
Vision	100% Employer Paid
Basic Life and AD&D	100% Employer Paid

Voluntary Offerings	
Short Term Disability	For information on rates please refer to the plan documents and enrollment materials. Rates may vary depending on factors such as age, coverage levels, or a flat rate structure
Long Term Disability	
Voluntary Life	
Aflac Indemnity and Supplemental Plans	
Met Life Supplemental Plans	
Health Flexible Spending Account (FSA)	Minimum of $260, Maximum of $3,400 for 2026 plan year
Dependent Care FSA	Please see pages **19-20** for more information

Please Note:

Medical/Rx deductions not received, need to be paid directly to Employee Benefits .

FSA and Voluntary Deductions not received, go into arrears. Deductions are taken by payroll in full immediately upon return.

Understanding Your Pre-Tax Benefit Payroll Deductions

The Section 125 Cafeteria Plan lets you pay for benefits like medical, dental, and vision with pre-tax dollars, reducing taxable income. Elections are locked in for the 12-month plan year unless a qualifying life event occurs.

Medical/Prescription Drug Coverage

Anthem

(833) 952-2024 - Medical
(833) 421-4717 - Prescription Drug
www.anthem.com

	Non-Deductible Plan*	Deductible Plan*
Network	National PPO (BlueCard PPO)	National PPO (BlueCard PPO)
DEDUCTIBLE	**Plan Year**	**Plan Year**
Individual	No deductible	$250
Family	No deductible	$500
COINSURANCE		
Plan Pays	80%	80%
You Pay	20%	20%
OUT OF POCKET MAXIMUM		
Individual	$2,000	$3,000
Family	$4,000	$6,000
COMMONLY USED SERVICES		
Preventive Care Services	100% Coverage	100% Coverage
Primary Care Physician Visit	$10 copay	$10 copay
Specialist Visit	$15 copay	$15 copay
Urgent Care Visit	$15 copay	$15 copay
Emergency Room Visit	$200 copay, waived if admitted	$200 copay, waived if admitted
Diagnostic Lab & Imaging	80/20%	80/20%
Hospitalization	80/20%	80/20%
Mental Health - Inpatient	80/20%	80/20%
Mental Health – Outpatient	$10 copay	$10 copay
Substance Abuse - Inpatient	80/20%	80/20%
Substance Abuse – Outpatient	$10 copay	$10 copay
Chiropractic	$10 copay	$10 copay

Higher out-of-pocket costs apply to all out-of-network services

Prescription Drug** Up to 90 Day Supply for Tier 1 & Tier II at Retail Pharmacy Same Rx level of benefit for Non-Deductible and Deductible Medical Plans	
Tier 1 Retail	20% (min $5, max $20) per 30-day supply
Tier 2 Retail	20% (min $40, max $100) per 30-day supply
Tier 3 Retail	20% (min $40, max $250) 30-day supply maximum

**See Summary Plan Description for additional details. You may also contact the plan administrator regarding benefits.*
***90-day available for Tier I and Tier II at retail and mail order available for 90-day copay. Tier III limited to 30-day supply.*

Create Your Member Account

Anthem provides online resources to help you make well-informed choices for care and make best use of your health care dollars. Our easy, handy tools let you access your ID cards, find a new doctor, compare health care costs and more.

You can register on the portal at www.anthem.com/register or you can download the Sydney Mobile App.

WHAT YOU CAN SEE ONLINE:

- Claims
- View explanation of benefits
- View benefits and eligibility
- Find a network doctor
- Find a pharmacy
- Estimate treatment costs

Access your benefits on the go with the Sydney Mobile App.

Download on the App Store

Available on the Google Play

Steps to Create Your Member Account:

- Visit www.anthem.com/register or scan the QR code and click **Log In**
- Scroll down and click **Register Now**
- Click **Member ID**
- Enter your Member ID and Group Number (found on the front of your medical ID card), first name, last name, date of birth and click **Next**
- Follow the remaining prompts to create your Anthem member account

www.Anthem.com/register

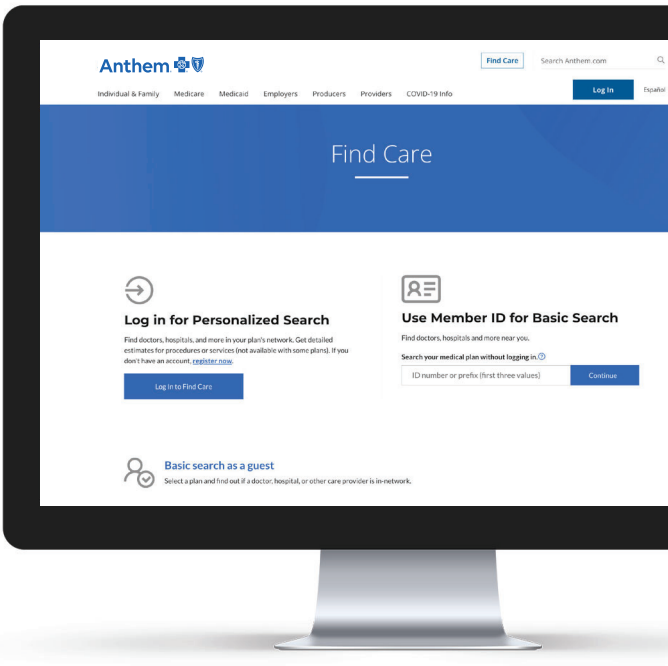
(833) 578-4439

How to search for a doctor in your plan's network

A step-by-step guide to finding care at anthem.com

Finding the care you need when and where you need it is important. That's why we've made it easier for you to find doctors in your plan's network at **anthem.com**.

Follow these steps to find care in your plan:



1. Go to **anthem.com/find-care**.

2. Search as a member or guest.

   For members — Select **Log in for Personalized Search** on the left. To help you find care providers who would be a good fit for you, we sort your search results and provide the top three matches using **Personalized Match.** There are more options available below your top three, and you can always re-sort these search results by distance or name.

   For guests — If you are not enrolled yet in an Anthem plan, you also can search as a guest. Choose **Basic search as a guest.** Then answer the questions regarding the type of care you need, the state you need care in, and the type of plan you want to search under.

   Select the type of plan or network — **medical plan or network.**

   - Choose the state where the plan or network is offered.(For employer-sponsored plans, select the state where your employer's plan is contracted in. Most of the time, it's where the headquarters is located.)
   - Select how you get health insurance - **Medical (Employer-Sponsored)**
   - Choose a plan or network — in this case, **National PPO (BlueCard PPO)**
   - Select the **Continue** button.

3. Enter your city, county, or ZIP code. You also can search by doctor, or procedure, as well as using other care-related terms.

4. View your search results. You can filter your results by selecting the relevant boxes on the left or browsing by list or map views.

Find care

You can start using the **Find Care** tool by visiting **anthem.com/find-care**.

¿Prefieres obtener información en español? Tienes opciones. Puedes visitar anthem.com/es.

* On-screen experiences may vary by user due to personalization experiences, benefit packages, and ongoing user-experience improvements.

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.

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Your pharmacy benefits

This benefits guide has tips on how to make the most of your coverage and save money too.

Benefit Links:
Formulary**:** **National Direct Plus 3 Tier**

Preventive List**:** **Preventive List**

Find a network pharmacy: **Pharmacy directory**

First things first. Have you registered at anthem.com yet?

While online, you'll be able to:

- Have prescription medications you take regularly delivered to your door with home delivery from CarelonRx Pharmacy.
- Find a pharmacy, price a medication, and refill or renew a prescription, plus track orders and shipping status in real time using online tools.
- Check your drug list (formulary) for a wide range of cost-effective medicines covered by your plan.
- Save more money when buying certain medications by using the Price a Medication tool in Sydney app. It helps you find the best price for medications in your plan's network.

With Sydney app, you can manage your benefits from anywhere. Download it at the Apple Store® (iOS) or on Google Play (Android).

Your drug coverage

Here is what your plan covers:

- Brand-name and generic drugs on your drug list
- Certain preventive drugs at little or no cost to you
- Specialty drugs if you have ongoing health issues or a serious illness

Your drug list

Your plan uses the **National Direct Plus Drug List**. It includes hundreds of generic and brand-name prescription drugs in every therapeutic class that can help keep your costs down. Choosing a medicine from your drug list can help you pay less — especially when compared to paying out of pocket for medicines that aren't covered.

For a more detailed list, log in at anthem.com. If your drug isn't on the list, you will see other options. Drug lists can change, so you may want to check it when you have a new prescription. We will send you a letter if a drug you take is removed from the list, and in some cases, if a drug you take is moved to a higher tier.

Medicines are grouped in tiers. Your share of the cost depends on which tier your medicine is on. Medications on lower tiers usually cost less.

Certain preventive medicines are at little or no cost to you in compliance with the Affordable Care Act (ACA) when specific criteria are met. To find out more, go to anthem.com/pharmacy-information.

Your plan uses the Preferred Generics program. This means when there's a generic option available and you choose to go with the brand-name drug instead, you'll pay more. Check with your doctor to see if there's a generic option that's right for you — it'll save you money!

Your pharmacy options

You have choices for filling your prescriptions, including local pharmacies in your plan and convenient home delivery from CarelonRx Pharmacy.

Retail pharmacies

Your plan includes nearly 67,000 pharmacies nationwide. You'll save the most money when you use one of your network pharmacies.

Vision Coverage: Blue View Vision

(866) 723-0515
www.anthem.com/find-care

Where Can I Go?

To maximize your vision benefit, use an in-network provider. Find a participating Blue View Vision provider at **www.anthem.com/find-care**.

	In-Network	Out-of-Network	Frequency
Routine Eye Exam	$0 copay	Up to $55 reimbursement	Once every 12 months
Frames/Lenses/Contacts	$100 allowance, then 20% off balance	Up to $100 reimbursement	Once every 12 months
Medically Necessary Contact Lenses	Covered in full	Up to $210 reimbursement	Once every 12 months

Benefit is per covered person, every 12 months from date of service/purchase
Reimbursement is manual, form available on our website

Additional savings available from in-network providers

When obtaining covered eyewear from a Blue View Vision provider, members may choose to upgrade their new eyeglass lenses at a discounted cost. Costs shown are after any applicable eyeglass lens copayment.

Description	Member Cost
Retinal Imaging (obtained at same time as covered eye exam)	Up to $39
Eyeglass materials purchased separately	20% off retail
Additional complete pairs of eyeglasses	40% off retail
Standard contact lens fitting and follow-up after comprehensive eye exam	Up to $55
Premium contact lens fitting and follow-up after comprehensive eye exam	10% off retail
Additional supplies of conventional contact lenses after benefits have been used	15% off retail
Other items including most non-prescription sunglasses, eyewear accessories such as lens cleaning supplies, contact lens solutions, eyeglass cases, etc.	20% off retail

Dental Coverage

DELTA DENTAL®

(800) 524-0179
www.deltadentaloh.com

	Delta Dental of Ohio PPO & Premier	
	In-Network	Out-of-Network
Type I—Preventive Services *	100% coverage	100% coverage
Type II—Basic Services *	80% after deductible	80% after deductible
Type III—Major Services *	70% after deductible	70% after deductible

**Refer to your plan document for coverage details*

Balance Billing: If you use an out-of-network provider, you will be charged the difference between what they billed and what your insurance allows. For example, if the charge is $100 and your insurance covers $70, you might get a bill for the remaining $30.

	Annual Deductible *Waived for Preventive Services*	
Individual	$25	$25
Family	$75	$75

	Maximum Benefits Limits	
Annual Limit:	$1,500	$1,500
Lifetime Limit: Orthodontics ***For dependent children to age 19**	$1,000	$1,000

Dental ID Cards: Delta Dental does not issue cards. Providers verify eligibility, coverage, and pay claims through member SSN.

Life Insurance

MetLife

(800) 638-5433
www.metlife.com

Designating a beneficiary ensures your life insurance goes to the right person, providing them support and avoiding legal issues.

Life insurance provides a monetary benefit to your beneficiary in the event of your death while you are employed at Lucas County. Accidental Death and Dismemberment (AD&D) insurance is equal to your life insurance benefit amount and is payable to your beneficiary in the event of your death as a result of an accident and may also pay benefits in certain injury instances.

Basic Life & AD&D is a 100% employer paid benefit with automatic enrollment. Please review/designate beneficiaries.

	BASIC LIFE & AD&D COVERAGE
Basic Life Insurance	$40,000
Accidental Death and Dismemberment	$40,000

Employees have the opportunity to elect to purchase Voluntary Life Insurance that provides an additional life insurance benefit for you, your spouse and/or your dependent child(ren). If you waive voluntary life coverage when you are initially eligible you will be required to provide Evidence of Insurability (EOI) when enrolling at a later date. EOI is the documentation of good health in order to be approved for coverage. The carrier will review and determine approval based on EOI documentation. Benefits may be limited and/or denied based on EOI results. Claims incurred prior to the approval of your coverage will not be covered.

	VOLUNTARY LIFE & AD&D COVERAGE		
	EMPLOYEE	SPOUSE	DEPENDENT CHILD(REN)
Increments	$10,000	$5,000	$2,500
Maximum	$500,000 or 5x Annual Salary	$100,000 or 50% EE Amount	$10,000

If you do not enroll when initially eligible, you may be required to submit Evidence of Insurability (EOI).

Actively at Work Requirement:

You must be actively at work on the day coverage is scheduled to begin. If you are not actively at work on that day, coverage for you will begin once you have returned to work.

Dependent Eligibility Requirement for Life Insurance:

A dependent confined to a hospital on the date on which insurance would normally begin will become insured upon discharge from the hospital.

Flexible Spending Accounts

HealthEquity

What is a Medical Flexible Spending Account?

A Flexible Spending Account (FSA) allows you to set aside money from your paycheck before income taxes (Federal, Social Security, Medicare, state and local taxes, if applicable) are withheld. This money is available to pay for eligible expenses, such as your medical deductibles and copayments, prescriptions, dental expenses, eyeglasses, contact lenses and other health-related expenses that are not reimbursed by your health plan.

How Does it Work?

You decide how much to contribute to your FSA on a plan year basis, up to the maximum allowable amount. Your annual election will be divided by the number of pay periods and deducted evenly on a pre-tax basis from each paycheck throughout the plan year.

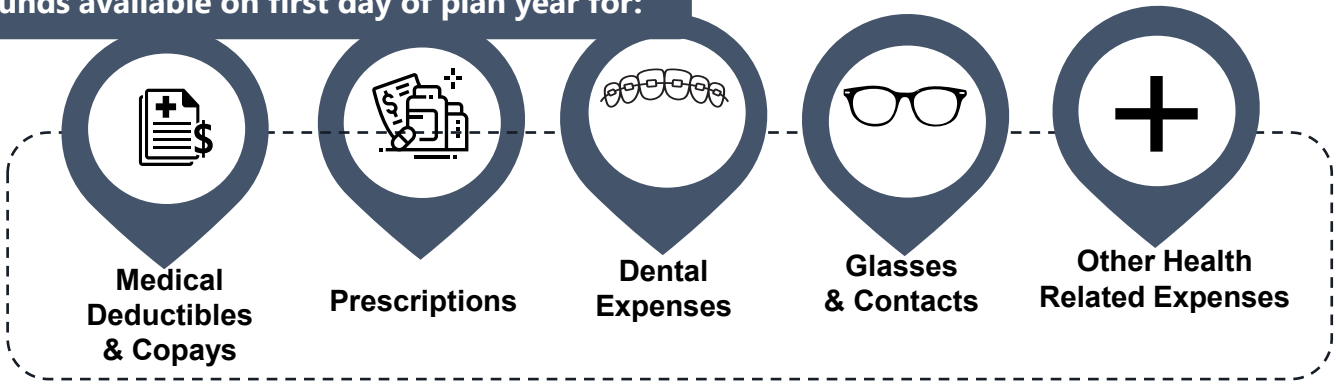
We have partnered with HealthEquity to manage your FSA.

Medical FSA Account: Things to Consider before you contribute:

- Be sure to fund the account wisely as Medical FSAs are subject to a "use it or lose it" rule. Any unused funds at the end of the year will automatically be forfeited.
- You are permitted to carryover up to $660 of unused funds at the end of the 2025 plan year, $680 for the 2026 plan year. Any amounts remaining more than $660/$680 will be forfeited.
- The IRS requires that FSA funds must be used within the plan year elected.
- You cannot take income tax deductions for expenses you pay with your Medical FSA &/or Dependent Care FSA.
- You cannot stop or change contributions to your FSA during the year unless you have a change in family status consistent with your change in contributions.
- Save your receipts for each eligible expense you submit for reimbursement. Receipts should include:
  - ✓ Name (who received the service)
  - ✓ Provider name (provider that delivered the service)
  - ✓ Date of service
  - ✓ Type of service
  - ✓ Cost of Service

2026 Annual Health FSA Maximum Contribution Limits	
Health FSA	$3,400

Funds available on first day of plan year for:



HealthEquity® | EZ Receipts

Flexible Spending Account

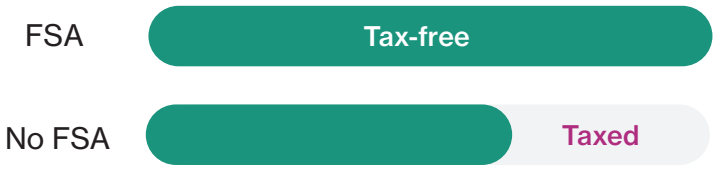
(with carryover)

A healthcare FSA lets you use tax-free money to pay for eligible medical, dental, and vision expenses.[1] So you spend less on the healthcare you need. FSA paycheck deductions are tax-free too, which helps reduce your taxable income. The more you contribute, the more you save.

- Carry part of your unspent funds into the next plan year.[2]
- Pay for your spouse and dependents too.
- Plan ahead because FSA funds eventually expire.

Less tax. More paycheck.

Get $20 tax savings for every $100 you contribute.[3]



FSA Contribution Limit[4]

$3,400

See how much you can save.

HealthEquity.com/Learn/FSA

Scan to download the EZ Receipts Mobile app.

Already enrolled? Please register your account online before using the app.

Spend tax-free on eligible expenses.

- Medical
- Dental
- Vision
- Rx and OTC

Discover more: HealthEquity.com/QME

[1]FSAs are never taxed at a federal income tax level when used appropriately for eligible healthcare expenses. Also, most states recognize FSA funds as tax deductible with very few exceptions. Please consult a tax advisor regarding your state's specific rules. | [2]See your plan documents for complete details. | [3]The example is for illustrative purposes only. Estimated savings are based on a maximum annual contribution and an assumed combined federal and state income tax bracket of 20%. Actual savings will depend on your contribution amount and taxable income and tax status. | [4]Contribution limit is accurate as of 10/09/25. Each fall the IRS updates the FSA contribution limits. For the latest information, please visit: HealthEquity.com/Learn | HealthEquity does not provide legal, tax or financial advice.

Dependent Care FSA

What is a Dependent Care FSA Account?

This is a pre-tax benefit account used to pay for eligible expenses for dependents under age 13 or care for disabled spouse or dependent that allows you - or you and your spouse - to work.

NEW in 2026: Increase in Dependent Care FSA Contribution Limits

Under the Dependent Care FSA, if you are married and file a joint return, or if you file a single or head of household return, the annual IRS limit is $7,500. If you are married and file separate returns, you can each elect $3,750 for the plan year. You and your spouse must be employed, or your spouse must be a full-time student to be eligible to participate in the Dependent Care FSA.

Claim Reimbursement ONLY

There is no card, reimbursement of claims only. You must fax, mail or submit your dependent care claim to the carrier for reimbursement.

Note: You can only be reimbursed for the money you put into the account. For example: if you have contributed $200 into your Dependent Care FSA, but your after-school care was $300 for the month, you can only be reimbursed for $200.

Things to Consider Before you Contribute to a Dependent Care FSA Account:

- Be sure to fund the account wisely as funds are "use it or lose it."
- There is NO rollover or runout period with Dependent Care Accounts.
- You must enroll in the dependent care FSA prior to the start of the plan year or during open enrollment (unless you experience certain qualifying life events).
- The following contribution limits apply based on tax filing status:
    - Single: $7,500 maximum
    - Married filing separate: $3,750 maximum
    - Married filing jointly: $7,500 maximum
        - Total of any contributions by both towards the maximum
- Save your receipts for each eligible expense you submit for reimbursement. Receipts should include:
    - ✓ Name (who received service)
    - ✓ Provider name (provider that delivered service)
    - ✓ Date of service
    - ✓ Type of service
    - ✓ Cost of service

2026 Annual Dependent Care FSA Maximum Contribution Limits	
Health FSA	$7,500/household $3,750 married, filing separately

Funds are available as they are deposited

HealthEquity®

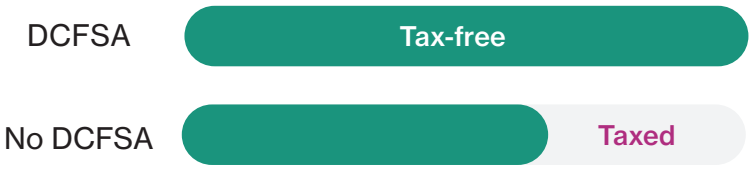
Dependent Care Flexible Spending Account

A DCFSA lets you use tax-free money to pay for eligible dependent care expenses.[1] A qualifying 'dependent' may be a child under age 13, a disabled spouse, or an older parent in eldercare. DCFSA paycheck deductions are tax-free too, which helps reduce your taxable income. The more you contribute, the more you save.

- Access funds as you make contributions.
- Enjoy fast, hassle-free reimbursement.
- Plan ahead because DCFSA funds eventually expire.

Less tax. More paycheck.

Get $20 tax savings for every $100 you contribute.[2]



DCFSA Contribution Limit[3]

$7,500

See how much you can save.
HealthEquity.com/Learn/DCFSA

Scan to download the HealthEquity mobile app.

Already enrolled? Set up your account directly in the app. No need to go online.

Spend tax-free on eligible expenses.

- Daycare
- Babysitter
- Elder care
- Preschool

Discover more: HealthEquity.com/QME

[1]DCFSAs are federally tax-deductible for eligible expenses and usually state-deductible; consult a tax advisor for details. | [2]Example for illustration only; savings based on a 20% federal and state tax bracket. | [3]Contribution limit accurate as of 07.14.2025. Limit increase effective 01.01.2026. See the latest info. at HealthEquity.com/learn | HealthEquity does not provide legal or tax advice.

Employee Assistance Program: Lighthouse EAP

419-475-5338
https://www.harbor.org/services/employee-assistance-program

Voluntary, Confidential & Free

We are interested in your total well-being. That is why we offer an Employee Assistance Program. This program provides a counseling service that helps you manage problems before they adversely affect your personal life, health and job performance.

It's unlikely today that any of us will make it through life without experiencing problems. The Board of Lucas County Commissioners recognizes that today's lifestyle is a challenge for people who juggle family, career and community obligations. It's understandable that the pressure can occasionally feel overwhelming and lead to challenges.

Program Details

An employee assistance program (EAP) is a valuable resource for employees who are facing personal or professional challenges that affect their well-being and performance. EAPs provide confidential and free counseling, referrals and other services to help employees cope with issues such as stress, anxiety, depression, substance abuse, family problems, financial difficulties, legal matters and more.

EAPs can also offer preventive services such as wellness programs, workshops and online resources to promote healthy lifestyles and prevent problems from escalating. EAPs can benefit both employees and employers by improving employee satisfaction, productivity, morale and retention, as well as reducing absenteeism, turnover, healthcare costs and workplace conflicts.

Contact Details

Lucas County provides a comprehensive Employee Assistance Program designed to support you in managing challenges that may impact your work or personal life.

Take advantage of these recourses by calling Lighthouse directly for any support needed.

Support & Counseling Available for:

- Marital and Family Relationships
- Financial Counseling and Management
- Elder Care and Aging Concerns
- Health and Wellness Resources
- Alcohol and Substance Abuse
- Personal and Work Stress
- Anger Management
- Grief and Loss Issues
- Depression
- Child Care
- Legal Services
- Domestic Violence
- Parenting
- *And many more!*

EAP BENEFIT REMINDER

Today. Tomorrow. Together.

Lucas County Ohio **EMPLOYEE ASSISTANCE PROGRAM** (EAP) is a *no-cost benefit* provided to all employees and eligible dependents. This benefit provides *confidential* access to *solution-focused* counseling and support for personal and/or work-life challenges.

LIGHTHOUSE EAP CAN HELP YOU BE YOUR PERSONAL BEST

- Relationships and family communication
- Managing stress and change
- Coping with grief and loss
- Substance abuse cessation support
- Managing anxiety and/or depression
- Life transitions and major decisions
- Workplace communication
- Parenting support and guidance
- Balancing work/life responsibilities
- Caregiver challenges and support
- Coping with diagnosed illness/pain
- Goal setting/motivation/action plans
- Anger management/domestic violence
- Trauma/critical incident support

YOUR LIGHTHOUSE EAP BENEFIT INCLUDES:

- **Confidential and Professional** short-term counseling and life coaching
- Up to **5 no-cost sessions** per presenting issue(s), per program year
- **24/7 Crisis Support** – professional guidance when you need it most
- **Household Coverage** includes spouse/partner, unmarried dependent child under age 26
- **Accessible Providers** (near work or home) for in-person, phone or video sessions (scheduler will help identify a convenient and appropriate location for you)

Solution-focused Counseling, Coaching, Referrals and 24/7 Crisis Support

Employee Assistance Program – Harbor Lighthouse

Lighthouse EAP
419.475.5338 or 800.422.5338

Effective date: 1/1/2026

Disability Insurance

(800) 638-5433
www.metlife.com

Short Term Disability: Insurance provides income protection in the event you become disabled and are unable to work due to sickness or non-occupational injury, including pregnancy, for a short period of time. Pleases see the summary plan description for complete plan details.

Long Term Disability: Insurance provides income protection in the event you become disabled and are unable to work for an extended period of time. Please see the summary plan description for complete plan details.

Short Term Disability	Long Term Disability
Benefit Amount	
60% of pre-disability earnings Flat increments of $50 with a minimum of $100	60% of pre-disability earnings
Benefit Maximum	
$1,250 per week	$5,000 per month
Definition of Disability	
Based on your own occupation	2-year own occupation, any occupation thereafter
Benefits Begin After	
7 days for accident 7 days for illness	180 days
Maximum Benefit Period	
25 weeks	3 years

*** Rates vary by age*

Note: If you waive voluntary disability coverage when you are initially eligible, you will be required to provide Evidence of Insurability (EOI) when enrolling at a later date. Please allow 4 to 6 weeks for underwriting review. Claims incurred prior to the approval of your coverage will not be covered. Benefits may be limited and/or denied based on the EOI results.

Actively at Work Provision:

You must be actively at work on the day coverage is scheduled to begin. If you are not actively at work on that day, coverage for you will begin once you have returned to work.

Accident Insurance

(800) 433-3036
www.aflacgroupinsurance.com

Accident insurance provides you with a cash payment if you get injured in an accident. This money can help cover medical bills, lost wages, or other expenses while you recover.

Accident insurance covers both short-and long-term injuries. Payments are made to you and not the healthcare provider, allowing you to use the funds however you see fit.

ACCIDENT INSURANCE COVERS INCIDENTS SUCH AS:

INJURIES
- ✓ Fractures
- ✓ Dislocations
- ✓ Concussions
- ✓ Lacerations
- ✓ Burns
- ✓ Eye injuries
- ✓ Ruptured discs

MEDICAL TREATMENT
- ✓ Ambulance
- ✓ Emergency care
- ✓ X-rays
- ✓ Hospital admission

HOSPITALIZATION
- ✓ Hospital admission
- ✓ Confinement

***Please see the Plans details for an explanation of benefits**

Benefits include, but are not limited to:	
Emergency Room/Urgent Care	$200
Emergency Room/Urgent Care with X-Ray	$250
Doctor's Office	$100
Ambulance – Ground / Air	$400 / $1,200
Concussion	$500
Lacerations	$50-$800

Coverage Tier	Monthly Cost
Employee	$11.22
Employee and Spouse	$19.03
Employee and Child(ren)	$25.27
Family	$33.08

Critical Illness

(800) 433-3036
www.aflacgroupinsurance.com

Critical illness insurance provides you with a lump sum payment if you're diagnosed with a serious illness like cancer, heart attack, or stroke. This money can help cover medical bills, lost income, or other expenses while you recover.

Benefit payments are determined by the medical diagnosis and coverage level. Payments are made to you and not the healthcare provider, allowing you to use the funds however you see fit.

SOME OF THE COVERED ILLNESSES INCLUDE:

- **Heart Attack**
- **Stroke**
- **Cancer**
- **Major Organ Transplant**
- **End Stage Renal Disease**
- **Coronary Bypass Surgery**

PLAN INCLUDES:

- Spouse/Children can elect up to 50% of employee's benefit
- Guarantee Issue - $30,000 for employees and $15,00 for spouse
- No waiting period
- Waiver of premium after 90 days of total disability due to a covered illness**

***Please see the Plans details for an explanation of benefits**

Employee Non-Tobacco Monthly Premiums

Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000
18-25	$1.17	$2.34	$3.51	$4.68	$5.86	$7.03
26-30	$1.61	$3.23	$4.84	$6.46	$8.07	$9.69
31-35	$2.05	$4.11	$6.16	$8.22	$10.27	$12.32
36-40	$2.66	$5.32	$7.99	$10.65	$13.31	$15.97
41-45	$3.53	$7.06	$10.59	$14.12	$17.65	$21.18
46-50	$4.69	$9.39	$14.08	$18.77	$23.47	$28.16
51-55	$7.31	$14.62	$21.93	$29.24	$36.55	$43.86
56-60	$8.73	$17.46	$26.19	$34.92	$43.65	$52.38
61-65	$14.34	$28.67	$43.01	$57.35	$71.68	$86.02
66+	$23.22	$46.44	$69.66	$92.88	$116.10	$139.32

Employee Tobacco Monthly Premiums

Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000
18-25	$1.53	$3.05	$4.58	$6.11	$7.63	$9.16
26-30	$2.17	$4.35	$6.52	$8.70	$10.87	$13.04
31-35	$3.03	$6.07	$9.10	$12.13	$15.17	$18.20
36-40	$4.16	$8.31	$12.47	$16.62	$20.78	$24.93
41-45	$5.51	$11.01	$16.52	$22.02	$27.53	$33.04
46-50	$7.30	$14.60	$21.91	$29.21	$36.51	$43.81
51-55	$11.56	$23.13	$34.69	$46.25	$57.82	$69.38
56-60	$14.43	$28.85	$43.28	$57.71	$72.14	$86.56
61-65	$23.12	$46.25	$69.37	$92.49	$115.62	$138.74
66+	$35.87	$71.75	$107.62	$143.50	$179.37	$215.25

Hospital Indemnity

(800) 433-3036
www.aflacgroupinsurance.com

Hospital indemnity insurance is a type of supplemental insurance that gives you a cash payment if you're hospitalized. This money can help cover costs that your regular health insurance doesn't pay for.

HOW YOU CAN USE IT:

- Deductibles
- Copays
- Everyday expenses while recovering

PLAN INCLUDES:

- Guarantee Issue
- No waiting period
- Non-HSA plan
- No pre-existing or pregnancy limitations

***Please see the Plans details for an explanation of benefits*

Hospitalization Benefits – Low / High Options	
Hospital Admission (per confinement) Once per covered sickness or accident per calendar year	$500 / $1,000
Hospital Confinement (per day)*	$100
Hospital Intensive Care (per day)* Day 1	$500 / $1,000
Intermediate Intensive Care (per day)* Day 2 to 10 /15	$50 / $200

***Please see plan for more details, maximum length of stay varies by plan*

Coverage Tier	Low Plan Monthly Cost	High Plan Monthly Cost
Employee	$7.42	$13.62
Employee and Spouse	$14.90	$27.58
Employee and Child(ren)	$12.08	$21.78
Family	$19.56	$35.74

Term to 120 – Life Insurance

(800) 433-3036
www.aflacgroupinsurance.com

Aflac Group Life Term to 120 offers guaranteed-issue living and death benefits, with the predictability of a whole-life plan. Rates will not increase, allowing you to help your family prepare for a secure future.

Please see the plans details for an explanation of benefits

Please see enrollment for rates

GROUP LIFE TERM 120

- **Guarantee Issue - Employee: Up to $150,000**
- **Guarantee Issue - Spouse: Lessor of $50,000 or 50% of Employee benefit**
- **Guarantee Issue - Child: $10,000**
- **No waiting period**
- **Fully portable for employees and spouses (not children)**
- **Accelerated Benefit**
- **Chronic conditions rider, living benefit when an insured loses 3+ activities of daily living**

***Please see the Plans details for an explanation of benefits**

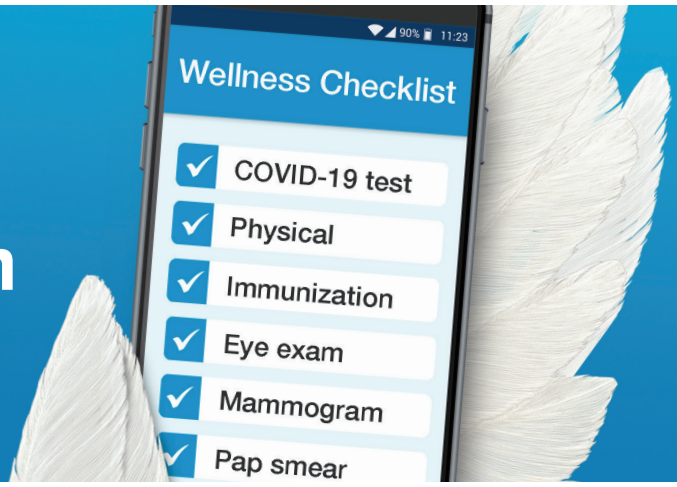
Employee Non-Tobacco Monthly Premiums

Issue Age	$25,000	$50,000	$75,000	$100,000	$125,000	$150,000
18-25	$11.75	$23.50	$35.25	$47.00	$58.75	$70.50
26-30	$13.67	$27.33	$41.00	$54.67	$68.34	$82.00
31-35	$16.19	$32.38	$48.56	$64.75	$80.94	$97.13
36-40	$20.31	$40.63	$60.94	$81.25	$101.56	$121.88
41-45	$26.27	$52.54	$78.81	$105.08	$131.35	$157.62
46-50	$34.27	$68.54	$102.81	$137.08	$171.36	$205.63
51-55	$47.54	$95.08	$142.63	$190.17	$237.71	$285.25
56-60	$70.08	$140.17	$210.25	$280.33	$350.42	$420.50
61-65	$91.21	$182.42	$273.63	$364.83	$456.04	$547.25
66-70	$140.90	$281.79	$422.69	$563.58	$704.48	$845.37

Employee Tobacco Monthly Premiums

Issue Age	$25,000	$50,000	$75,000	$100,000	$125,000	$150,000
18-25	$15.29	$30.58	$45.88	$61.17	$76.46	$91.75
26-30	$18.44	$36.88	$55.31	$73.75	$92.19	$110.63
31-35	$23.21	$46.42	$69.63	$92.83	$116.04	$139.25
36-40	$29.31	$58.63	$87.94	$117.25	$146.56	$175.88
41-45	$37.67	$75.33	$113.00	$150.67	$188.34	$226.00
46-50	$49.90	$99.79	$149.69	$199.58	$249.48	$299.38
51-55	$68.19	$136.38	$204.56	$272.75	$340.94	$409.13
56-60	$101.33	$202.67	$304.00	$405.33	$506.67	$608.00
61-65	$142.90	$285.79	$428.69	$571.58	$714.48	$857.38
66-70	$213.94	$427.88	$641.81	$855.75	$1069.69	$1283.63

Don’t forget to file your wellness claim



There could be cash waiting for you

As part of your benefits package, you had the chance to sign up for an Aflac plan. Your plan helps with expenses health insurance doesn’t cover, and benefits can be used in any way you want – whether that’s to pay unexpected medical bills or everyday living expenses.

Aflac wants to put money into your pocket by encouraging you to file a wellness claim. Put simply, many of our plans provide an annual benefit for proactively managing your health with a COVID-19 screening or antibody test, annual physical or eye exam, mammogram, pap smear, prostate exam or another covered exam.*

Filing a claim is easy: Simply log in to **www.aflac.com/myaflac** or download the MyAflac® mobile app and follow the instructions to file a claim. Don’t want to wait for a check? Signing up for direct deposit will get your money to you faster.

Scan QR code for MyAflac app

Available on the App Store

GET IT ON Google Play

Remember: Checkups = Aflac checks. Don’t leave your money on the table.

Continental American Insurance Company
In California, Continental American Life Insurance Company

Aflac®

*These are examples of common exams that may be covered under your wellness benefit and not a guarantee of benefits paid. Coverage varies by state and plan selected. Please refer to your certificate for details and a list of covered exams.

AGC2001496R5

EXP 5/26

Additional Offerings through MetLife

MetLife

(800) 638-5433
www.metlife.com

MetLife Group Legal Plan

MetLife Legal Plans provide employees with valuable resources to manage legal issues, enhancing both their financial and emotional well-being. Unlike other benefits, the more employees use the Legal Plan, the more they benefit, with access to over 18,000 experienced attorneys for unlimited consultations, court representation, and trials for covered matters.

The plan includes best-in-class digital tools for creating essential legal documents like wills and powers of attorney in as little as 15 minutes. Integrated service and administration simplify setup, while customizable communications ensure employees can easily access support. Additionally, financial wellness programs like workshops and the MetLife Personal Finance app empower employees to make informed financial decisions.

Your Cost / Month	**$17.25 per employee (Covers spouse and dependents)**

Identify Theft

MetLife has partnered with Aura to offer comprehensive identity theft protection as part of your employee benefits.

Aura provides proactive monitoring, alerts, and recovery assistance to safeguard your personal and financial information. Together, MetLife and Aura help protect what matters most, giving you peace of mind in today's digital world.

Protection Plus	Individual	Family
Your Cost / Month	$8.45	$13.95

Pet Insurance

Aflac Pet Insurance
POWERED BY trupanion

(877) 232-4605
https://www.aflac.com/individuals/products/pet-insurance.aspx

Pet insurance helps cover the costs of veterinary care and other expenses.

PET INSURANCE COVERS THINGS SUCH AS:

- Emergency Care (broken bones, cuts or ingestion of toxic substances)
- Surgeries
- X-rays & Diagnostic Tests
- Chronic Conditions
- Medications
- Antibiotics

*** Rates vary by pet*

Aflac and Trupanion have joined forces to offer an employee benefit that helps protect furry family members from unexpected veterinary expenses. Aflac provides financial protection and peace of mind, allowing policyholders to focus on recovery instead of financial stress. Trupanion, with over 20 years of experience, insures more than 800,000 pets, offering coverage for unexpected injuries and illnesses.

3 Plans to Choose From:

Unlimited Accident & Illness	Basic Accident & Illness	Accident Only
Covers certain pre-existing conditions	Covers new unexpected illnesses or injuries	Covers new unexpected injuries
Covers new unexpected illnesses or injuries	24/7 telehealth veterinary support	Coverage starts on the first of the month (no waiting periods)
24/7 telehealth veterinary support	Coverage starts on the first of the month (no waiting periods)	
Coverage starts on the first of the month (no waiting periods)		

The Trupanion pet insurance will not be payroll deducted from Lucas County, there will be a link out on the enrollment site where you can enroll using direct billing.

Frequently Asked Questions

1. How much will it cost per pay if I enroll in either a single, family or family-spouse primary medical/prescription drug plan?
   Single Non-Deductible Plan: $34.62
   Single Deductible Plan: $16.15

   Family Non-Deductible Plan: $57.69
   Family Deductible Plan: $34.62

   Family-Spouse Primary Non-Deductible Plan: $184.62
   Family-Spouse Primary Deductible Plan: $184.62

2. What is the difference between the Non-Deductible Plan and the Deductible Plan?
   The plans have different deductibles, out of pocket maximums and employee share costs.

   Non-Deductible Plan
   Deductible: None
   Out of Pocket Maximum: $2,000/Individual and $4,000/Family
   Employee Cost per Pay: $34.62/Singe, $57.69/Family, $184.62/Family-Spouse Primary

   Deductible Plan
   Deductible: $250/Individual and $500/family
   Out of Pocket Maximum: $3,000/Individual and $6,000/Family
   Employee Cost per Pay: $16.15/Singe, $34.62/Family, $184.62/Family-Spouse Primary

3. When is the Deductible applied?
   Only for services when your 80%/20% co-insurance is involved. It is $250 for an individual and $500/family per plan year and the deductible is applied toward your out-of-pocket maximum. If you are enrolled in a family plan and one person reaches the $250 deductible that person would then have straight 80/20% co-insurance for the remainder of the plan year. One (1) or more persons in the family would make up the remaining $250 to max at $500 for the family. Deductibles are imposed once per plan year.

4. Can I sign up for a single medical/prescription drug plan for myself and enroll in a family vision and family dental plan and cover my kids and husband or would I have to sign up for a family medical/prescription drug plan in order for them to receive the dental and vision?
   You can enroll in a single medical/prescription drug plan and then enroll in a family dental and family vision plan at no additional cost.

5. I am married to another County employee who is also eligible. What option do we enroll in?
   Married County employees are eligible to enroll in 2 single medical/prescription drug plans or 1 family medical/prescription drug plan and the other will need to waive. Both employees are eligible to enroll in family vision, family dental and Basic Life & AD&D, at no additional cost.

6. How long are dependent children eligible for benefits?
   Dependent children are covered until the end of the calendar month in which they turn 26.

Frequently Asked Questions

7. How can I verify if our current provider(s) are in our Anthem network?

   https://www.anthem.com/find-care/?alphaprefix=901

8. How can I find what pharmacies are in our pharmacy network?
   https://file.anthem.com/BaseCentralBCBS.pdf
   Kroger is in our pharmacy network effective 3/1/2025.

9. How can I determine which Tier our medications are covered at under Anthem/ Carelon?

   Main | Formulary Search

10. My spouse works for an employer and has access to insurance coverage, are they required to take it?
    Employees have the option of enrolling their spouse as secondary in a family plan for $75/125 per month or you could enroll in family-spouse primary for $400 per month.

11. Will I need a referral to see an in-network specialist?
    No, you do not need referrals on either medical plan to see a specialist.

12. Can we still go to a Center of Excellence, for example, Cleveland Clinic, University of Michigan?
    Employees can still utilize a Center of Excellence in our Anthem network. Cleveland Clinic and University of Michigan are both in network. We have eliminated the $500 deductible barrier for utilizing a Center of Excellence. Please always verify network participation before receiving services.

13. My spouse also has Anthem through their employer, is it beneficial for me to add spouse as secondary on my plan?
    It depends on the other employer's level of benefits. Our benefit level is high so it could be advantageous to have spouse secondary here.

If you're turning 65, you may be wondering about Medicare.

Are you Turning 65 this year?

For information on Medicare eligibility and enrollment periods, please visit www.Medicare.gov.

You may also reach out to the Hylant Medicare Advisory Center at **(855) 574-8822** or via email at MedicareAdvisoryCenter@hylant.com.

Preventive Wellness Screening Attestation Form
March 1, 2026 - February 28, 2027

Any employee enrolled in a medical plan who completes at least 4 of the below recommended screenings during plan year 2026; March 1, 2026 through February 28, 2027, will be eligible for $125 added to your paycheck. This will be a 1 (one) time annual payment to be administered quarterly on one of the following pay-dates: 5/22/2026, 8/28/2026, 12/04/2026, 3/12/2027. Employee must be employed at the time of payout to be eligible. Screenings are subject to audit by Employee Benefits.

It is recommended you consult with your physician before obtaining any recommended screening.

Wellness Physical Date Completed: _____

Bloodwork Date Completed: _____

Cholesterol Screening Date Completed: _____

Dental Cleaning Date Completed: _____

Vision Exam Date Completed: _____

Hearing Screening Date Completed: _____

Mammogram Date Completed: _____

Pap Smear Date Completed: _____

Colonoscopy Date Completed: _____

Osteoporosis Screening Date Completed: _____

Prostate Screening Date Completed: _____

I hereby attest that I have completed at least 4 of the above recommended screenings during plan year 2026; March 1, 2026 through February 28, 2027.

Print Name: _____

Signature: _____ Date: _____

Email completed form to employeebenefits@co.lucas.oh.us no later than March 1, 2027.

Know Where to Go

If you're faced with a sudden illness or injury, making an informed choice on where to seek medical care is crucial to your personal and financial well-being. Making the wrong choice can result in delayed medical attention and may cost hundreds, if not thousands, of dollars. More than 10 percent of all emergency room visits could have been better addressed in either an urgent care facility, a doctor's office or a virtual visit through Telehealth.

	Features	Conditions Treated	Cost
Anthem Virtual Care 	• Convenient, low-cost option for treating common, non-urgent health concerns. • A doctor will diagnose the issue over the phone and write a prescription, if necessary • Generally available 24/7	• Acne • Allergies • Cough/sore throat • Diarrhea • Insect bites • Pink eye • Rash	**$0**
Primary Care 	• Call or see your primary care physician for your regular medical problems • Established relationship, can treat based on knowledge of medical history • Generally limited hours	• Annual wellness screenings $0 • Immunizations • Minor injuries, such as sprains • Common illnesses • Management of chronic conditions • Health advice • Medication refills or changes	**$10**
Urgent Care 	• Treatment of non-life-threatening injuries or illnesses • Staffed by physicians • Generally open nights and weekends; some open 24/7	• Cold and flu symptoms • Minor accidents or falls • Minor sprains or fractures • Minor cuts and burns • Nausea, vomiting, diarrhea • Earaches • Eye infection • Urinary tract infection • Allergic reaction • Animal or insect bite	**$15**
Emergency Room 	• Immediate treatment for serious, life-threatening conditions • Ready to treat any critical situation • Can be hospital-based or freestanding • Available 24/7, 365 days/year	• Chest pain • Difficulty breathing • Severe abdominal pain • Broken bones • Head injuries • Uncontrolled bleeding • Seizures • Coughing or vomiting blood • Severe burns	**$200**

REMEMBER: Unless it is a true emergency – a serious or life-threatening condition that requires immediate treatment that is only available in a hospital – consider your options for appropriate, quality care that is efficient and economical.

Anthem digital EOB

A step-by-step guide to accessing your explanation of benefits

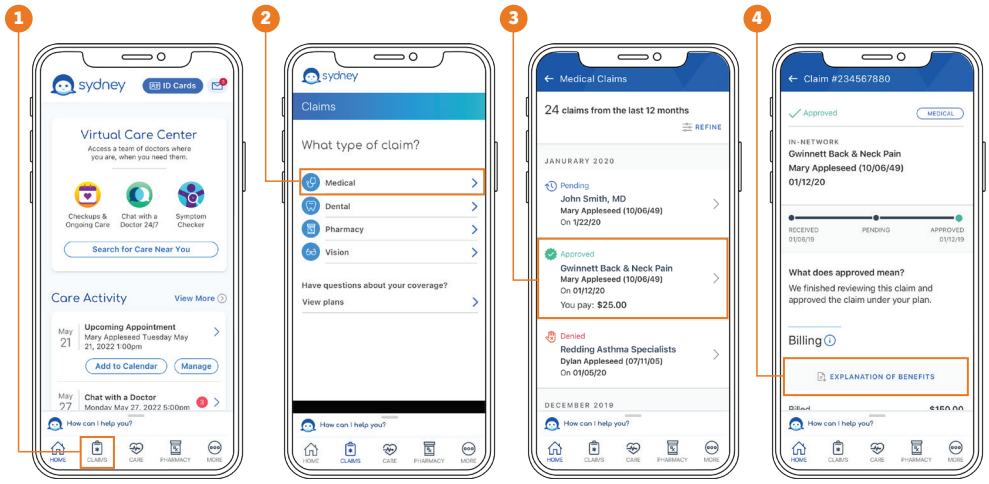
With your digital explanation of benefits (EOB), you'll never have to wait for your EOB to arrive in the mail. You can instantly check your EOBs for the last two years whenever it's convenient simply by using your smartphone or computer.

Find your digital EOB on the Sydney℠ Health app:

1. Go to *Claims*
2. Select **Medical**, **Dental**, **Pharmacy**, or **Vision**
3. Go to the claim you want to review
4. Choose **EOB**

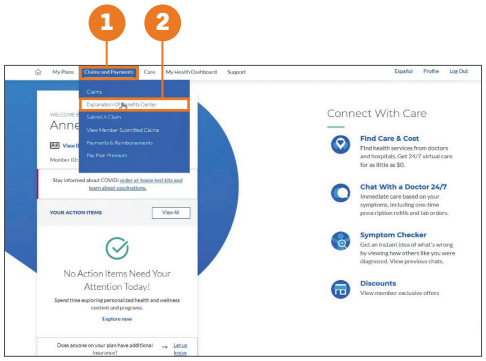
Download the Sydney Health app today in the Google Play™ or App Store®.

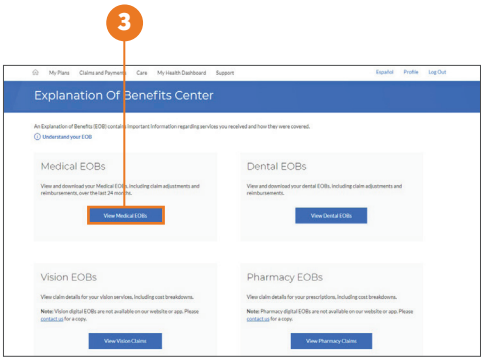
Download on the App Store | GET IT ON Google Play

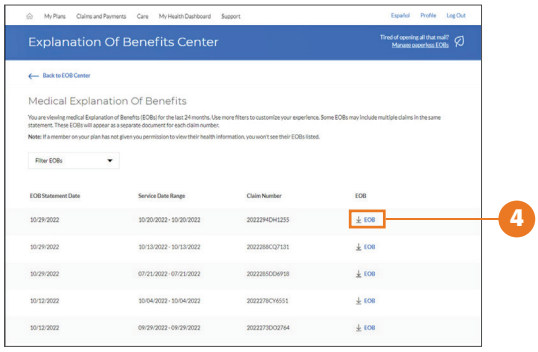


Find your digital EOB on anthem.com:

1. Go to *Claims and Payments*
2. Select **Explanation of Benefits Center**
3. Choose **Medical**, **Dental**, **Pharmacy**, or **Vision**
4. Choose **EOB**







If you have questions, use the chat feature on Sydney Health or **anthem.com**, or call Member Services at the number on your ID card.

If you prefer to get your EOB by mail

Change your *Communications & Settings* preferences on Sydney Health or **anthem.com**, or call Member Services at the number on your ID card.

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

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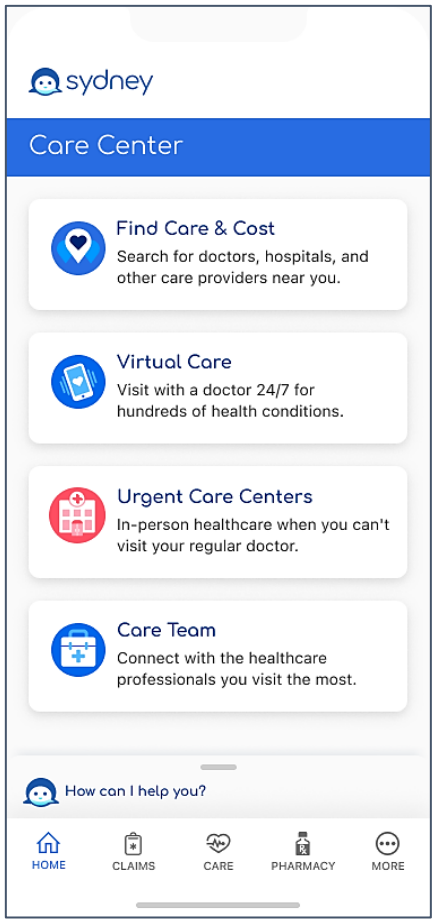
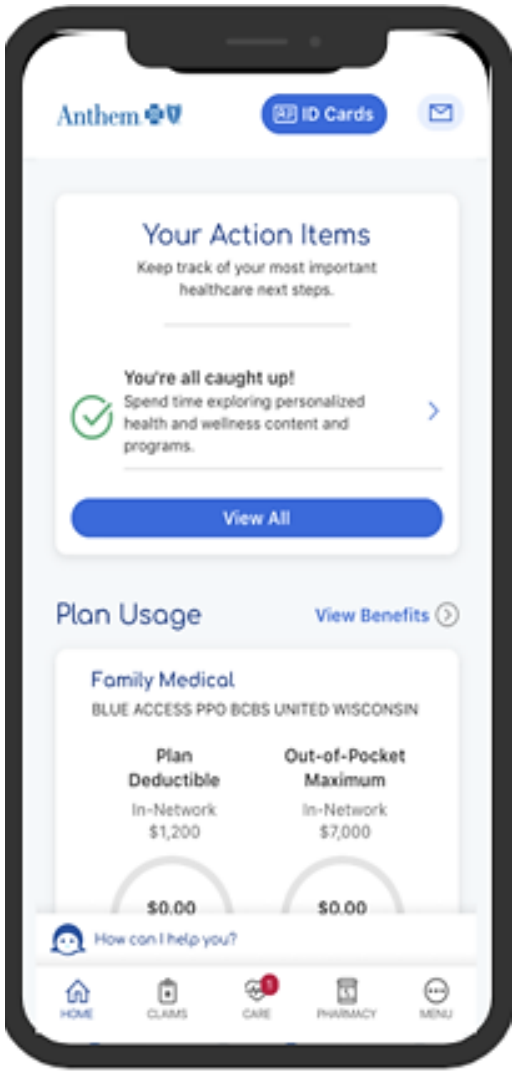
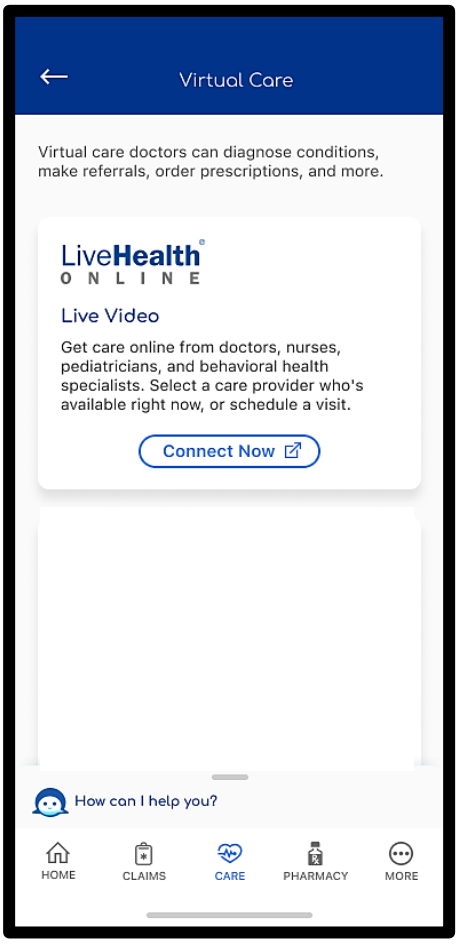
Anthem Virtual Care Center







LiveHealth Online Virtual Care:

- Live Video Meetings, ≥12+ years old
- Urgent Care
- Annual Wellness Exams
- Primary Care Visits
- Psychology & Psychiatry visits
- Members can choose and establish an ongoing relationship with a provider for primary care needs
- Labs,/Imaging, e-prescriptions & refills, in network provider referrals

Anthem

The Care Center: One access point to comprehensive virtual care

This benefits is provided to you at no cost, 100% paid by your employer!

Accessible through our award-winning Sydney Health app, the Care Center connects employees to:

Primary care

Expanded video access to primary care with an Appointment.
The ability to schedule care with the same provider
on an ongoing basis

Urgent care

Available 24fi/365 with no appointment needed

Condition management

Ongoing care for chronic conditions like diabetes
and hypertension, coordinated by a care team

Behavioral health

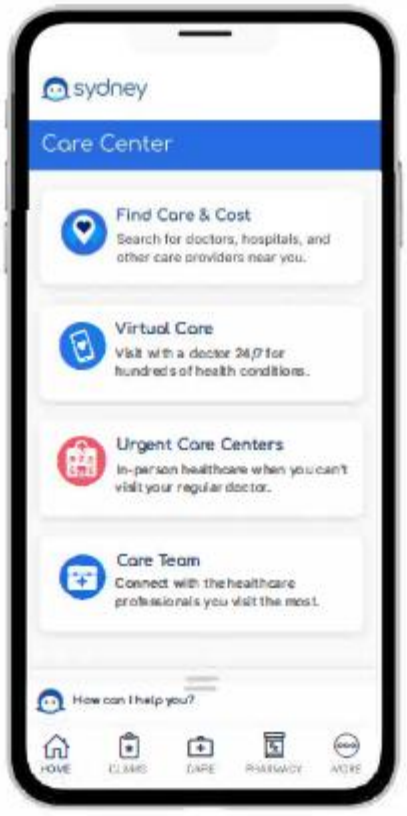
Integrated behavioral health and data sharing between
virtual primary care (VPC) and mental health providers
to support whole-person health

Wellness visits

Annual preventive care
(wellness) visits by video for employees ages 18 to 64

Specialized support

Access to clinical expertise for support when, where,
and how employees need it most



With the Sydney Health app you can also:

- Obtain New Prescriptions and refills
- Schedule Labs and Imaging services
- Obtain Referrals
- Set up Reminders for checkups, tests and exams

Pharmacy Benefit Resources

To find an In-Network Pharmacy near you, visit: **Anthem In-Network Pharmacy**
To view the formulary (Medication List), visit: **Anthem Preferred Drug List**

Mail Order

If you take maintenance medications for long-term conditions such as arthritis, diabetes, high blood pressure or high cholesterol, home delivery could be a fit for you. Through Anthem CarelonRx's home delivery service, you receive a 90-day supply of your maintenance medication directly to your home.

How to Get Started with Home Delivery Service:

Ask your doctor to write two prescriptions:

1. 30-day supply to fill right away at your local pharmacy
2. 90-day supply with refills to start your home delivery service

Mail your 90-day prescription and home delivery order form with payment information

➢ *Forms can be found on our website or contact Employee Benefits*

Visit **anthem.com** and login to your member account

- Choose **Pharmacy**, then select **View Your Prescriptions** under **Switch to a 90-day Supply**
- For prescriptions you want to switch to home delivery, choose **Switch to a 90-day Supply**, then click Select Prescriber

Submit your refill orders and pay online through your secure member portal.

Call the home delivery pharmacy at (833) 419-0530 with your Rx number and payment information.

Complete the refill section on the home delivery order form and mail it to the address listed on the form.

Anthem

BioPlus Specialty Pharmacy for all your specialty pharmacy needs

Offering a personalized, user-friendly experience

When you need a specialty medication, BioPlus has you covered.

Specialty medications treat chronic and complex conditions. They can be more expensive, require more paperwork, and have different side effects than other medications. With 30 years of experience and high customer satisfaction, BioPlus, CarelonRx's specialty pharmacy, uses advanced digital tools and personalized interactions to make filling your specialty medications fast and easy.

How does it work?

Your doctor prescribes a specialty medication and sends the prescription directly to BioPlus.

BioPlus contacts you to confirm receipt of your prescription. Once your order is ready to ship, BioPlus will contact you to get any necessary information and schedule your delivery. They will also discuss financial assistance if you are eligible.

BioPlus ships the prescription to your home or to your doctor's office. You will also receive instructions on how to access your online welcome kit.

Anthem | carelon Rx

How can BioPlus help you?

If you have questions about BioPlus or your specialty prescription, please call **833-549-2114**.

To find out if a specialty medication is covered under your plan, please visit anthem.com or go to the **Sydney**SM **Health app**.

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24/7 NurseLine

Giving you and your family access to a registered nurse anytime

Your health is priceless. That is why it is so important for you to be able to connect to the resources and expert guidance you need to keep you safe and healthy — day or night.

24/7 NurseLine serves as your first line of defense for unexpected health issues. You can call a trained, registered nurse to decide what to do about a fever, give you allergy relief tips, or advise you where to go for care. A nurse is always available to help answer your questions.

A registered nurse can also:

- Help you find doctors, hospitals, and specialists in your area.
- Give you referrals to LiveHealth Online, an option for care that allows you to have a video visit with a board-certified doctor.
- Enroll you in health management programs for certain health conditions.
- Remind you about scheduling important screenings and exams, including dental and vision checkups.
- Provide guidance during natural catastrophes and health outbreaks.
- Offer links to health-related educational videos or audio topics.

When you use 24/7 NurseLine, you also have access to Anthem's other health and wellness programs to help you achieve your personal wellness goals.

We understand the need for care to be accessible. When you need guidance on how to protect your health, we are here to support you for any issue — big or small. For help, call 24/7 NurseLine at **888-249-3820.**

Anthem

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Anthem | lark

Preventing diabetes just got easier

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:

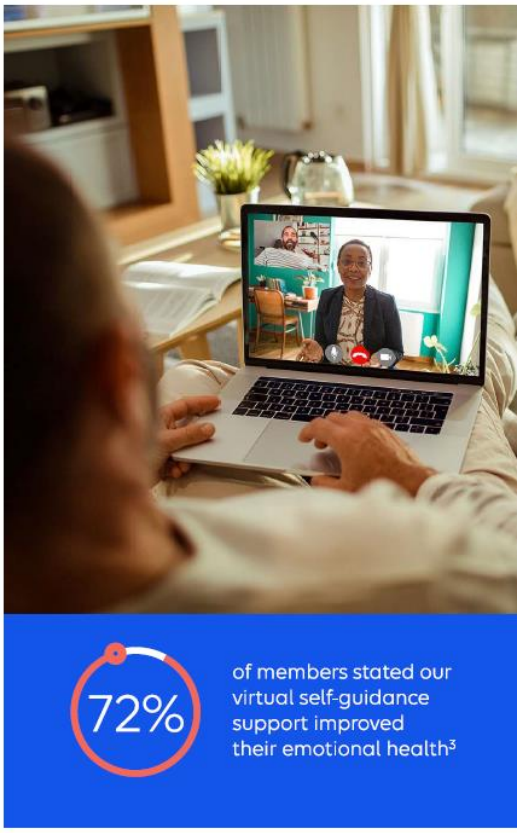
- Create healthy eating habits
- Reach or maintain a healthy weight
- Make time for physical activity
- Manage stress levels
- Improve sleep quality
- Set and reach your health goals

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.



Virtual behavioral health

Easily Connect with Mental Health Support through the Virtual Care Center with low or $0 copay

Services include:

- Video visits with in-network licensed **psychologists, therapists,** and **psychiatrists** for medication management
- Private, easy to access, and **convenient visit**
- **Self-scheduled appointments** available 7 days a week
- **Appointments available within 7 days for therapy and 30 days for psychiatry**

Commonly treated behavioral health concerns

- Anxiety
- Stress
- Depression
- Grief
- Coping with an illness
- Obsessive compulsive disorder (OCD)
- Post traumatic stress disorder (PTSD)
- Bipolar disorder (BO)

Schedule video visits 7 a.m. to 11 p.m. 7 days a week

1. Your doctor will determine if a prescription is needed
2. Specific to LiveHealth Online
3. Anthem Internal data, Commercial members, 2022

Anthem learntolive

Emotional Well-being Resources

Support for your well-being goals

Digital tools available anywhere, anytime

Your emotional well-being is an important part of your overall health. With Emotional Well-being Resources, administered by Learn to Live, you can learn effective ways to manage:

- Stress
- Worry
- Depression
- Sleep issues
- Anxiety
- Panic
- Drug and alcohol use
- Social anxiety

Complete an assessment and enroll in a program to get started. Work toward your goals with someone who can guide and support you along the way.

Extra motivation starts with a coach and teammates

Adding a coach can lead to more program success:[1]

Our experienced coaches keep all your information confidential. They are trained to guide you through your program and offer personalized suggestions to help you reach your emotional well-being goals. A coach can:

- Offer education, practical and personal support, and tips to make lessons easier to follow.[2]
- Provide ways to overcome obstacles and help ease stress.[3]

Another great option: select teammates

You can also add one or two friends and family — or even your therapist — as your teammates. They can cheer you on as you move through the programs and keep you motivated. Your teammates don't see all your program details, just the progress you're making.

1 Learn to Live internal data.

2 U.S. National Library of Medicine: *A Qualitative Study of How Health Coaches Support Patients in Making Health-Related Decisions and Behavioral Changes* (accessed March 2023): ncbi.nlm.nih.gov.

3 U.S. National Library of Medicine: *Social support moderates stress effects on depression* (accessed March 2023): ncbi.nlm.nih.gov.

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Start building your support team

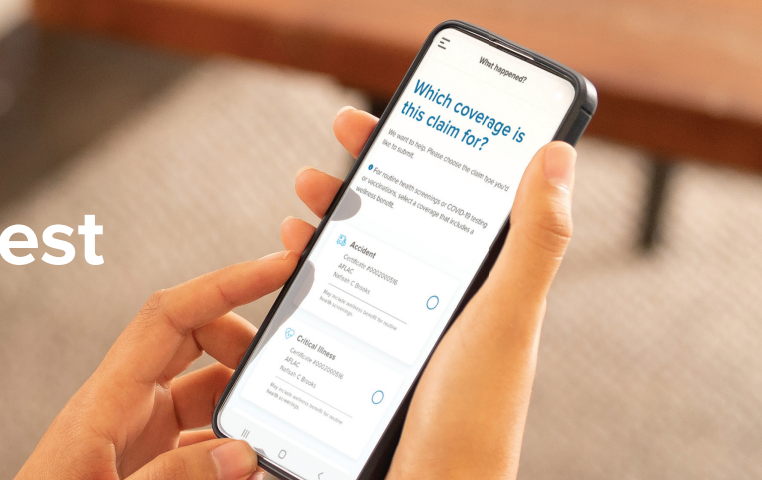
To access Emotional Well-being Resources:

Visit and enter your company code to log in: .

Download the Sydney℠ Health app, choose **Menu,** select **My Health Dashboard,** go to *Featured Programs,* and choose **Emotional Well-being Resources.**

Log in to **anthem.com,** go to *My Health Dashboard,* choose **Programs,** and select **Emotional Well-being Resources.**

File your claims with MyAflac® for the easiest way to get paid fast



MyAflac gives you an end-to-end, self-service experience:*

Access your account anytime, from anywhere on our website or MyAflac mobile app.

Enable biometric login for convenient access using your thumbprint or facial recognition.

Follow a guided, step-by-step claims submission process.

Submit documents directly by phone.

Sign forms electronically.

Enroll in direct deposit.

View coverage details, claims history and download/print an ID card.

Enjoy a streamlined path to submit wellness claims and receive wellness benefits from all eligible coverage based on a single claim.

Be confident you're getting paid all eligible benefits because we check all of your Aflac coverages based on a single claim.

Scan the QR code to download the MyAflac mobile app, access your account online and find helpful claims resources.

Aflac®

*This flyer describes the user experience for Aflac Group certificate holders. MyAflac functionality may vary depending on type of coverage.

Continental American Insurance Company | Columbia, SC

AGC2201080

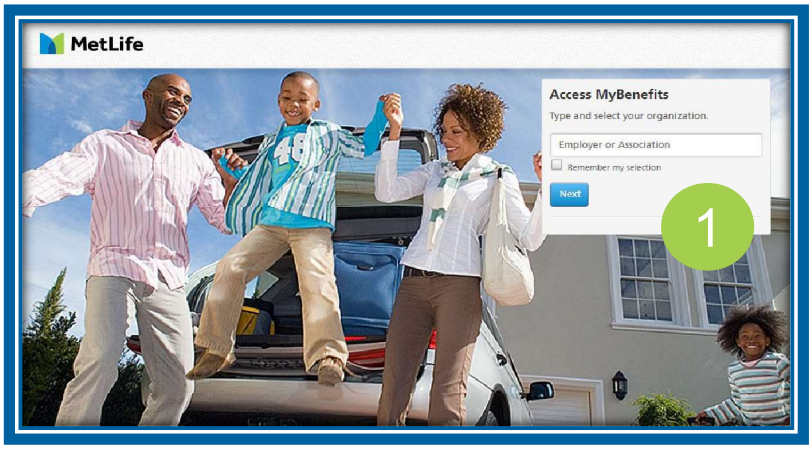
EXP 9/23

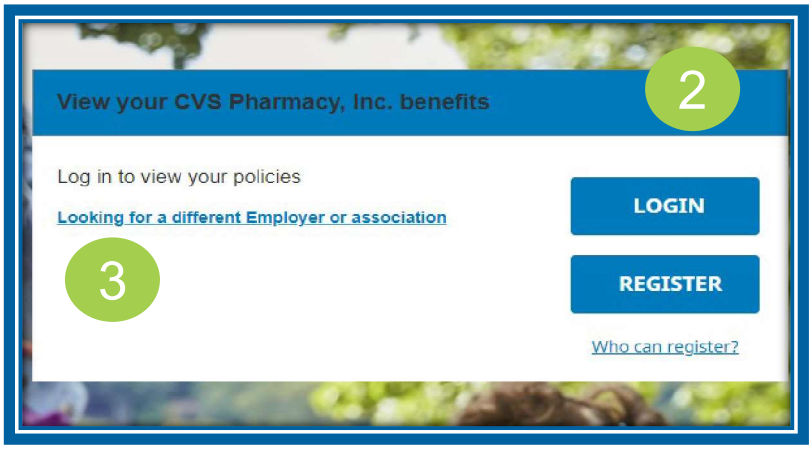
MetLife

A Step-by-step Guide to MyBenefits Registration

Pre-Registration

1. Upon navigation to either online.metlife.com/benefits or mybenefits.metlife.com, you'll see the screen on the right. Enter the name of your employer or organization into the field in the upper-right corner. A dropdown menu of organizations may appear with options to choose from (if more than one match is found, select the organization you want to register and click "Next").
2. You'll be taken to a screen that asks you to select whether you would like to login or register. The interface may vary.
3. Regardless of the interface, select "Create a New Account" or "Register Now." If you believe you have selected the wrong organization, click on the link that reads "Looking for a different Employer or association. This link will take you back to the screen where you can choose a different organization.

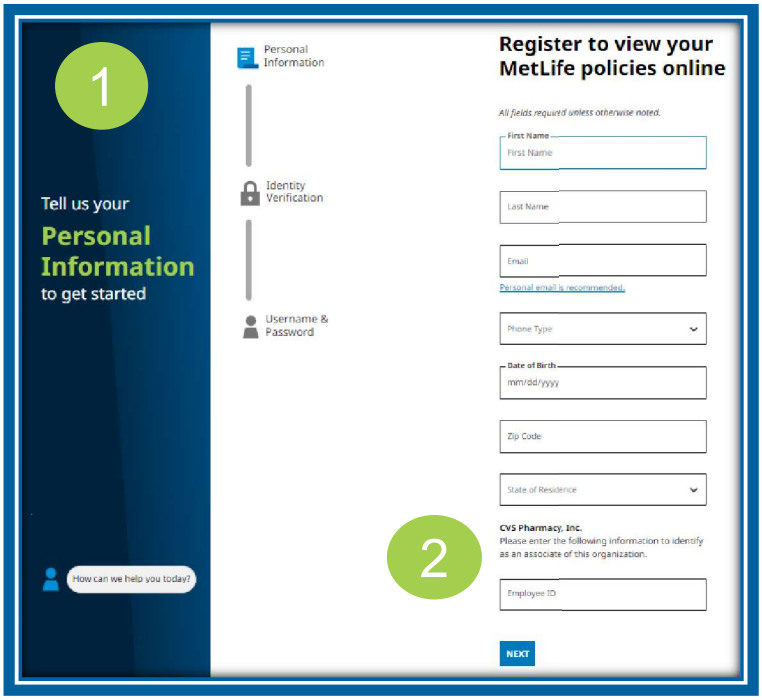




Registration

From here, you'll be taken to Step 1 of the registration process.

1. Enter your personal information: first name, last name, email address. Select the type of phone number you have (mobile or landline) and enter your US based phone number, DOB, zip code and state.
2. After entering all this information, you may be prompted to enter information specific to your employer or organization, depending on how your organization has set up its registration process. For example, you may be asked to enter your Employee ID or SSN. Upon entering the information, click "Next".



MetLife

Registration Continued

3. If your identifying information does not match publicly available information about your identity, you may be prevented from creating an account.

   Next, you'll be asked to verify your identity via a **verification code** on the screen below. Select whether you'd like to receive the code via text message or voice message, and sometimes an email if that information is already available to MetLife.

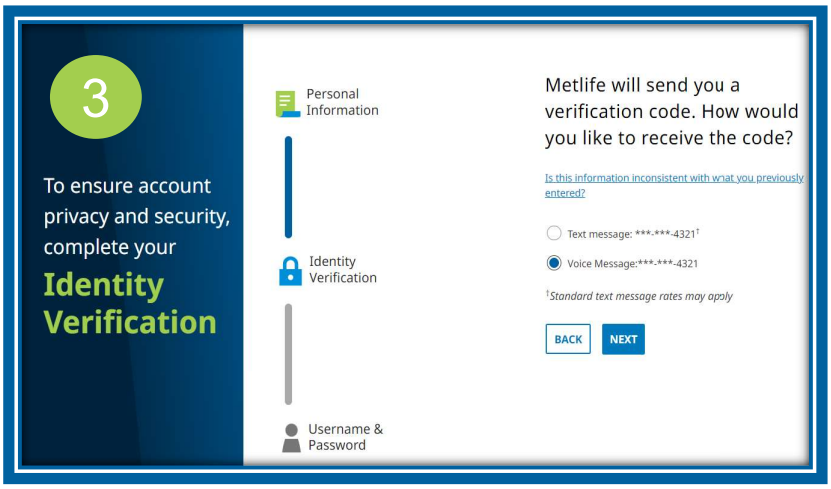
4. You'll be taken to the 2nd screen on the right. Retrieve the code, then enter it in the text field. The code will expire after 15 minutes, in which case you will need to generate another code. Click **"Next"**.

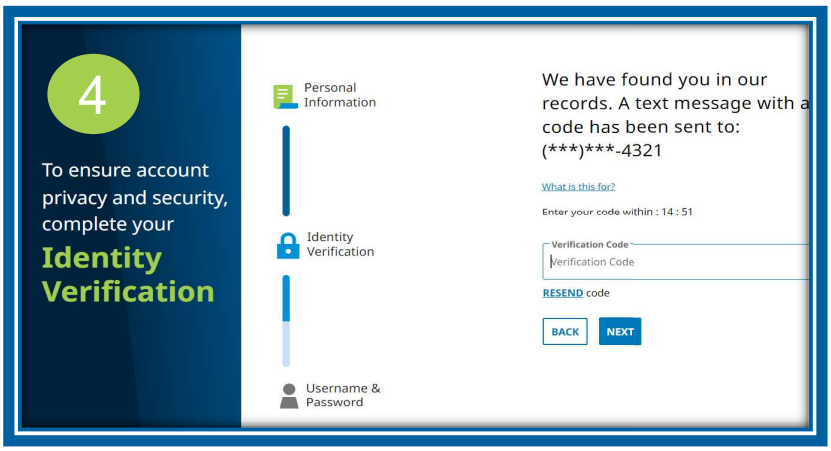
5. Your email address will be a suggested username in the first text field. We recommend using this as your username, but you may change it. Enter and confirm your desired password in the next two text fields.

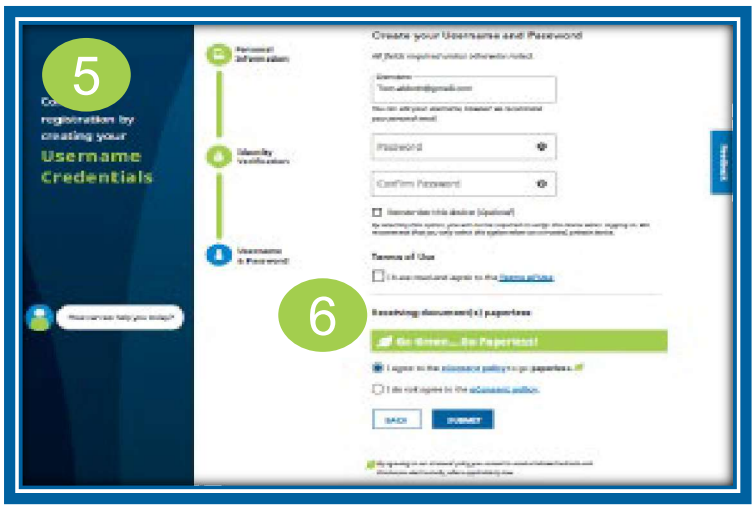
   If you'd like MetLife to remember your device, so that you don't have to verify your identity every time you login to your online account, select the **"Remember this Device"** checkbox. Your device will be remembered for a maximum of six months.

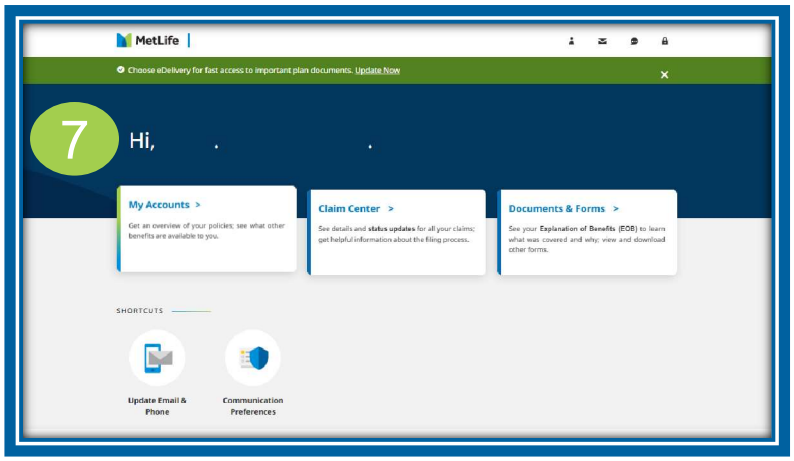
6. Decide whether you'd like to receive documents electronically by selecting one of the radio buttons at the bottom of the page. You may view the relevant links. Click "Submit". Upon successful submission, you should receive a congratulatory confirmation message.

7. Finally, select "Go to Dashboard" and you will be taken to your Dashboard.









1095-C Tax Form Notice

We wanted to share some important news about legislation impacting ACA reporting requirements.

On December 23, 2024, the president signed two pieces of legislation into law—the **Paperwork Burden Reduction Act (HR 3797)** and the **Employer Reporting Improvement Act (HR 3801)**—that streamline the Affordable Care Act's (ACA) reporting requirements under Internal Revenue Code Sections 6055 and 6056. These changes are aimed at simplifying compliance and reducing administrative burdens for employers.

Applicable Large Employers (ALEs) and other reporting entities are no longer required to proactively distribute Forms 1095-C to employees. However, these forms are available to employees upon request.

Lucas County will no longer mail employees their 1095-C Form. Employees may request their 1095-C Form from employeebenefits@co.lucas.oh.us, 419-213-4189, or One Government Center Suite 440, Toledo, OH 43604. We have 30 days from the date of request to furnish the form.

LUCAS COUNTY BOARD OF COMMISSIONERS

Colleen Abbott, HIPAA Privacy Officer
One Government Center, Suite 440
Toledo, Ohio 43604
(419) 213-4189
Cabbott@co.lucas.oh.us

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

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

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

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

Get a copy of your health and claims records	• You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct health and claims records	• You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. • We are not required to agree to your request, and we may say "no" if it would affect your care.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in payment for your care • Share information in a disaster relief situation *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive	• We can use your health information and share it with professionals who are treating you.	***Example:*** *A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*
Run our organization	• We can use and disclose your information to run our organization and contact you when necessary. • **We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.** This does not apply to long term care plans.	***Example:*** *We use health information about you to develop better services for you.*
Pay for your health services	• We can use and disclose your health information as we pay for your health services.	***Example:*** *We share information about you with your dental plan to coordinate payment for your dental work.*
Administer your plan	• We may disclose your health information to your health plan sponsor for plan administration.	***Example:*** *Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

continued on next page

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

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

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests and work with a medical examiner or funeral director	• We can share health information about you with organ procurement organizations. • We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

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

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

This Notice of Privacy Practices applies to both Protected Health Information (PHI) and to Substance Use Disorder ("SUD") treatment records as provided in 42 C.F.R. Part 2 ("Part 2"). We do not sell or use your PHI or Part 2 SUD records for fundraising. You have the ability to use a single consent form for the release of PHI and SUD records for treatment, payment and health care operations. If we receive records under this consent, we can redisclose them in accordance with the HIPAA regulations. Your Part 2 SUD records and testimony cannot be used against you in civil, criminal, administrative or legislative proceedings without your written consent or a court order issued after you have been notified and given the opportunity to be heard.

Our Responsibilities

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

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

Changes to the Terms of this Notice

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

Effective: December 17, 2025

This Notice of Privacy Practices applies to the following organizations.

This Notice of Privacy Practices applies to the Lucas County Board of Commissioners' Health, Prescription, Vision and Dental plans and the Wellness Program.

Colleen Abbott, Privacy Officer
One Government Center, Suite 440
Toledo, Ohio 43604
(419) 213-4189; Cabbott@co.lucas.oh.us

Important Terms

Balance Billing When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. An in-network provider typically may not balance bill you for covered services.

Brand A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine. You generally pay a higher copay for brand name drugs, and your employer pays a higher amount when the claim is paid as well.

Coinsurance After you meet the deductible amount, you and the plan share the cost of covered expenses. Coinsurance is always a percentage totaling 100%. For example, if your plan pays 70% of the coinsurance, you pay the remaining coinsurance share, 30% of the cost.

Copayment or Copay A form of medical cost-sharing whereby a member pays at time of service (or purchase for prescription drugs) a fixed dollar amount, regardless of whether you have met your deductible for the year.

Deductible The fixed amount of cost-sharing you are responsible for during the benefit period before the plan will pay. The deductible typically does not apply to preventive care and certain other services. Plans may have both per individual and family deductibles. Deductibles may differ if services are received in-network versus out-of-network.

Evidence of Insurability (EOI) A medical questionnaire used to determine whether an applicant will be approved or declined for coverage. This may be required for certain types of insurance coverage.

Explanation of Benefits (EOB) The statement made available to a member by their carrier after services have been received and the claim has been processed, which lists the services received, amount paid by the plan, and the amount to be paid by the member.

Formulary A list of prescription drugs covered by the plan that will be used to determine the coverage for the drug based on the tier the drug is listed.

Generic Medications that have the same active ingredients, dosage, and strength as their brand-name counterparts. Generic drugs generally have the same efficacy as their brand name counterparts at a much lower cost for you and your employer.

Guaranteed Issue When an insurance policy is offered to any eligible applicant without regard to the health status of the individual that applies. Typically, no health questionnaires (EOI) or exams are required.

Health Savings Account (HSA) A tax-free, individually owned savings account used to pay for you and your eligible dependents' insurance deductibles and qualified out-of-pocket medical, dental and vision expenses. Account owners must be enrolled in a high-deductible health plan and have no access to first dollar coverage such as Medicare or Direct Primary Care. Money deposited in an HSA stays with you, regardless of employer or plan, and unused balances roll over year to year. The employer and the employee can contribute to the HSA up to the annual limit for an individual or a family as stated by IRS guidelines.

High-Deductible Health Plan (HDHP) Also called a "Consumer Driven Health Plan" (CDHP), has lower premiums and higher deductibles than a traditional health plan. With the exception of preventive care, employees must meet the annual deductible before the plan pays benefits, even for office visits and prescriptions.

IMPORTANT TERMS

Imputed Income The cost or value of certain benefits must be added to an employee's gross income, referred to as "imputed income," so that it can be taxed accordingly. Common examples include employer-paid life insurance exceeding $50,000, the value of health coverage provided for a domestic partner or child who is not a tax dependent, and, in limited circumstances, voluntary or employee-paid life insurance.

In-network Doctors, clinics, hospitals and other providers with whom the plan has an agreement to care for its members. Plans cover a greater share of the cost for in-network providers than for providers who are out-of-network, and the member pays a lower amount for those services.

Non-Preferred Brands These medications generally have generic alternative and/or one or more preferred brand options within the same drug class which causes these drugs to cost more. You and your employers usually pay more for non-preferred brand medications. Also known as non-formulary brands.

Out-of-Network A physician, healthcare professional, facility or pharmacy that doesn't participate in the plan's network and doesn't provide services at a discounted rate. Using an out-of-network healthcare professional or facility will cost you more.

Out-of-Pocket Maximum The maximum dollar amount a member is required to pay out of pocket for allowable covered expenses under a plan during a benefit period before the plan will pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or services your plan doesn't cover. Some plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit.

Preferred Drug A list of prescription medicines that are preferred based on an evaluation of effectiveness and cost. Another name for this list is a "formulary" or "formulary brand." The plan may charge more for non-preferred drugs or for brand name drugs that have generic versions. Drugs not on the preferred drug list may not be covered.

Payroll Deduction The amount you pay out of your paycheck in order to be enrolled in the medical, dental and/or vision insurance plans and possible other offered benefits.

Prior Authorization/Pre-Service Notification The decision by the plan that a service, treatment plan, prescription drug, medical equipment, or other services defined in the certificate of coverage and/or Summary Plan Description (SPD), is medically necessary. The plan may require preauthorization for certain services before receiving them, in order for the service to be covered.

Provider A physician (medical, dental or vision), healthcare professional or health care facility licensed, certified or accredited as required by state law recognized for payment by the plan.

Qualifying Event An occurrence defined by IRS Section 125 such as marriage/divorce, death, termination of employment, child birth/adoption, involuntary loss of coverage, etc. which triggers an employee's ability to make changes to their benefit elections at the time the qualifying event occurs outside of open enrollment.

Usual, Customary and Reasonable (UCR) The determined going rate for a service in a geographic area based on what providers in the area usually charge for the same or similar service. The UCR amount is sometimes used to determine the allowed amount and is used typically when services are provided by an out-of-network provider.

Important Plan Notices, Disclosures & Legal Documents

Note to All Employees
Certain Federal Regulations require employers to provide disclosures of these regulations to all employees. The remainder of this document provides you with the required disclosures related to our employee benefits plan. If you have any questions or need further assistance, please contact your Plan Administrator.

Board of Lucas County Commissioners, Colleen Abbott
One Government Center, Suite 440, Toledo, OH 43604 | employeebenefits@co.lucas.oh.us
(419) 213-4189

Name of Group Health Plan: Board of Lucas County Commissioners Health Plan

Notice Regarding Special Enrollment Rights

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

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

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within **30 days** after the marriage, birth, or placement for adoption. **(Note pre-tax payments may not be made for retroactive coverage due to marriage.)**

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

To request special enrollment or obtain more information, please contact your Plan Administrator (identified at the beginning of this section).

Notice Regarding Women's Health and Cancer Rights Act (Janet's Law)

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Refer to your benefit materials for specific deductibles and coinsurance that apply.

If you would like more information on WHCRA benefits, please call your Plan Administrator (identified at the beginning of this section).

- One year after the medically necessary leave of absence began.
- The date the coverage would otherwise terminate under the terms of the plan.

A written certification by the treating physician is required. The certification must state that the dependent child is suffering from a serious illness or injury and that the leave is medically necessary. Provisions under this law became effective for plan years beginning on or after October 9, 2009.

HIPAA Privacy

The Plan complies with the privacy requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These requirements are described in a Notice of Privacy Practices that was previously given to you. A copy of this notice is available upon request to the Plan Administrator (identified at the beginning of this section).

Health Insurance Marketplace Coverage Options and Your Health Coverage

To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

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

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.5% (indexed annually) of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.5% (indexed annually) of the employee's household income. (An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.)

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution - as well as your employee contribution to employment-based coverage - is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact your Plan Administrator (identified at the beginning of this section)..

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

***When balance billing isn't allowed, you also have these protections*:**

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:

- Cover emergency services without requiring you to get approval for services in advance (also known as “prior authorization”).
- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you’ve been wrongly billed, or for more information about your rights under Federal law, contact the Center for Medicare & Medicaid Services at https://www.cms.gov/nosurprises/consumers. The federal phone number for information and complaints is: 1-800-985-3059

In addition to federal law, you may have protections available to you through state law. If state law protection is available, contact information will be included on your Explanation of Benefits (EOB) for any applicable services.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility –

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

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor	U.S. Department of Health and Human Services
Employee Benefits Security Administration	Centers for Medicare & Medicaid Services
www.dol.gov/agencies/ebsa	**www.cms.hhs.gov**
1-866-444-EBSA (3272)	1-877-267-2323, Menu Option 4, Ext. 61565

Turning Age 65 and Becoming Medicare Eligible

If you are an active employee and have reached the age of 65, you may be wondering about Medicare. If you are already receiving Social Security benefits, you should receive an advisory notice from Medicare about three (3) months before your 65th birthday for your initial enrollment period. Otherwise, you must actively enroll in Medicare yourself by contacting your local Social Security office as you will not receive a mailed notice of eligibility.

If you are turning age 65 during the plan year but will continue working in a benefits-eligible position, you have the option of enrolling in Medicare Part A (hospital) coverage, which is typically premium-free. You may also enroll in Part B (medical) coverage and Part D (prescription drug) coverage at your cost. If you do enroll in Medicare, this plan and Medicare will coordinate benefits with one plan paying as primary and the other paying as secondary, as determined by Federal law. When Medicare is primary, some carriers require the participant enroll in Medicare Part B; members should call their medical carrier member services line to identify when this is required.

For additional information on Medicare eligibility and enrollment periods, please visit www.Medicare.gov.

Medicare Part D Coverage Notice – Important Information About Your Prescription Drug Coverage and Medicare

Please note that the following notice only applies to individuals who are or will become eligible for Medicare in the next 12 months.

Medicare eligible individuals may include employees, spouses or dependent children who are Medicare eligible for one of the following reasons.

- Due to the attainment of age 65
- Due to certain disabilities as determined by the Social Security Administration
- Due to end-stage renal disease (ESRD)

You are responsible for providing this notice to your spouse, your domestic partner or any dependent who is or will become Medicare eligible in the next 12 months. If your spouse, your domestic partner, or any dependent resides at a different address then you, please contact us to provide that individual's address as soon as possible.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Group Health Plan (as identified at the beginning of this section) and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The prescription drug coverage offered by the Group Health Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 through December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage through the Group Health Plan and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage…

Contact your Plan Administrator (identified at the beginning of this section). You will receive this notice each year and again if this coverage through your company changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit U.S. Social Security on the web at **www.socialsecurity.gov** or call 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Wellness Program Privacy Notice

The Board of Lucas County Commissioners Wellness Program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

You are not required to participate in the Wellness Program.

The information from your screenings, blood test or other medical examinations, will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information.

Although the wellness program and the Board of Lucas County Commissioners may use aggregate information it collects to design a program based on identified health risks in the workplace, the Wellness Program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) your doctor in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Employee Benefits at (419) 213-4189, One Government Center Suite 440, Toledo, OH 43604.

Notice of Rescission of Coverage

Under Health Care Reform, your coverage may be rescinded (i.e., retroactively revoked) due to fraud or intentional misrepresentation regarding health benefits or due to failure to pay premiums. A 30-day advance notice will be provided before coverage can be rescinded.

Summary of Benefits & Coverage (SBC)

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

The Summary of Benefits & Coverage (SBC) is a document intended to help people understand their health coverage and compare health plans when shopping for coverage. The federal government requires all healthcare insurers and group healthcare sponsors to provide this document to plan participants. SBCs will be created for each medical plan offered. Group health plan sponsors must provide a copy of the SBC to each employee eligible for coverage under the plan. The SBC includes:

- A summary of the services covered by the plan

- A summary of the services not covered by the plan
- A glossary of terms commonly used in health insurance
- The copays and/or deductibles required by the plan, but not the premium
- Information about members' rights to continue coverage
- Information about members' appeal rights
- Examples of how the plan will pay for certain services

The SBC's are available online at https://co.lucas.oh.us/236/MedicalPrescription-Drug-Insurance. A paper copy is also available, free of charge, by contacting your Plan Administrator: 419-213-4189.