



CLERMONT
COUNTY OHIO

2025 BENEFITS GUIDE





Inside the Guide

Welcome

At Clermont County we recognize our ultimate success depends on our talented and dedicated workforce. We understand the contribution each employee makes to our accomplishments and so our goal is to provide a comprehensive program of competitive benefits to attract and retain the best employees available.

Use this guide to help you choose the type of plan and level of coverage that is right for you.

As you prepare to enroll: Review and compare all of your available insurance options. Gather information you'll need. If you are covering dependents, you will need their dates of birth and Social Security numbers. Be prepared to provide dependent documentation if requested – such as marriage license or birth certificates.

You can view benefit plans by accessing the County Employee Benefits website, www.hr.clermontcountyohio.gov.

Enrollment & Eligibility	3
Medical	4
Savings & Spending Accounts	5-6
CarelonRx	7-8
LARK Diabetes Prevention	9-10
Live Health Online	11
Tobacco Cessation	12
Wellness Program	13-15
Employee Assistance Program (EAP)	16
Dental	17
Vision	18
Life and AD&D	19
Long Term Disability	20
Supplemental Plans	20
Family Medical Leave Act (FMLA)	21
Deferred Compensation Plans	21
COBRA Rights	21
MyBenefits2GO Mobile App	22
Benefit Resource Center	22
Required Annual Legal Notices	23



Log in to ESS Benefits



Elect your Benefits



Check dependent



Save and submit



Print your elections

<https://clermontauditor.munisselfservice.com/login.aspx>

Some of the information herein may not apply to employees who are part of a Collective Bargaining Group (union): Please refer to your Department Head or Collective Bargaining agreement for specific information for your particular office/department.

Enrollment

Open Enrollment

With few exceptions, Open Enrollment is the only time of year when you can make changes to your benefit elections. All elections and changes take effect on the first day of the plan year. During Open Enrollment, you can:

New Hires & Newly Eligible

Coverage begins 1st of the month following 30 days of full-time employment. Ex.: If your hire date were 03/15/2025, your benefits would be effective 05/01/2025 (this is your "eligibility date").

- You have 30 days from your eligibility date to elect your benefits; we recommend that you elect coverage ASAP to avoid delays with ID cards, coverage and to avoid back-deductions.

Returning from Military Leave

Return from disability or military leave: Your coverage resumes immediately or when any existing coverage ends.

Mid-Year Changes Due to a Qualifying Event (QE)

- A QE is a circumstance affecting your family status or income such as marriage, birth, adoption, legal separation, divorce, death, loss of other coverage, newly available coverage, etc. A qualifying event must be reported to the employer within 30 days of the actual event.

Coverage Ends

All health and life insurance benefits will end on the last day of the month in which you leave county employment or become ineligible for benefits.

Dependent coverage will end on the day of the event when the event is divorce, legal separation or death of dependent; dependent coverage for all other QE's will end on the last day of the month in which the dependent becomes ineligible for coverage.

Eligibility

Eligible Employees:

Clermont County Health, Life and Disability benefits are available to all permanent, full-time employees and persons elected or appointed to elected office, unless otherwise mandated by the **Patient Protection and Affordable Care Act** (PPACA).

Supplemental Benefits:

All permanent employees with regularly scheduled hours equaling 20 hours per week or more, including persons elected or appointed to an Elected Office. **See supplemental benefits section for specifics regarding enrollment*

Eligible Dependents:

If you are eligible for our benefits, then your dependents maybe too. In general, eligible dependents include:

- Legal spouse (per federal guidelines)
- Your children up to age 26. Children may include natural, adopted, stepchildren and children obtained through Court appointed guardianship.
- Dependent children who were deemed disabled prior to age 19 may also qualify for benefits past the age of 26.

Family Status Change:

A change in family status is a change in your personal life that may impact your eligibility or dependent's eligibility for benefits. Examples of some family status changes include:

- Change of legal marital status
- Change in number of dependents
- Change in employment or job status

If such a change occurs, you must make the changes to your benefits **within 30 days of the event date**. Enter your request into ESS/Benefits under "Life Event: and provide documentation to: Teresa Igo, Benefits Coordinator, Human Resources,

Medical

	Anthem BCBS Medical Premium Copay	Anthem BCBS Medical Basic Copay	Anthem BCBS Medical HDHP/HSA
	In-Network	In-Network	In-Network
Annual Deductible			
Individual / Family	\$2,000 / \$4,000	\$5,000 / \$10,000	\$3,300 / \$6,000
Coinsurance (after deductible)	80%	90%	90%
Maximum Out-of-Pocket			
Individual / Family	\$5,000 / \$10,000	\$6,000 / \$12,000	\$4,000 / \$8,000
Physician Office Visit AFTER DEDUCTIBLE			
Primary Care	\$10 copay	\$35 copay	90%
Virtual Visit	\$10 copay	\$35 copay	90%
Specialty Care	\$50 copay	\$70 copay	90%
Preventive Care	No charge	No charge	No charge
Diagnostic Services AFTER DEDUCTIBLE			
Outpatient Radiology and Lab	80%	90%	90%
Urgent Care Facility	\$25 copay	\$75 copay	90%
Emergency Room Facility Charges	\$300 copay	\$350 copay	90%
Inpatient & Outpatient Facility	80%	90%	90%
Carelon Rx Retail Pharmacy (30 Day Supply) AFTER DEDUCTIBLE			
Generic (Tier 1)	\$15 copay	\$15 copay	90%
Preferred (Tier 2)	\$50 copay	\$50 copay	90%
Non-Preferred (Tier 3)	\$70 copay	\$100 copay	90%
Preferred Specialty (Tier 4)	\$70 copay	\$100 copay	90%
Carelon Rx Mail Order Pharmacy (90 Day Supply) AFTER DEDUCTIBLE			
Generic (Tier 1)	\$30 copay	\$30 copay	90%
Preferred (Tier 2)	\$100 copay	\$100 copay	90%
Non-Preferred (Tier 3)	\$140 copay	\$200 copay	90%

Employee Contributions (per pay / 24 pays per year)	Medical Premium Copay	Medical Basic Copay	Medical HDHP/HSA
Single	\$44.03	\$10.00	\$30.00
EE + Spouse	\$135.60	\$115.26	\$98.96
EE + Child(ren)	\$109.68	\$93.23	\$79.14
Family	\$196.98	\$167.43	\$141.57

Health Savings Account Contribution (per pay) (when electing HDHP): Single Coverage: \$25 / All Other Coverage: \$50

Medical Plan Spousal Surcharge: \$50 per pay extra for spousal coverage if the spouse has medical available through their own employer

Tobacco User Rates: \$25 upcharge per pay (in addition to selected plan rate)

Savings & Spending Accounts

We offer several tax-advantaged options to help you save money. These accounts let you use pre-tax dollars for health care or dependent day care expenses you're already paying for. Review this chart to understand what accounts you are eligible for and how they work.

	Health Savings Account (HSA)	Healthcare Flexible Spending Account (FSA)
What can I use this account for?	<p>Eligible out-of-pocket medical, prescription drug, dental and visions expenses for yourself and eligible your dependents</p> <p>Example of eligible expenses include:</p> <ul style="list-style-type: none"> • Deductibles • Copays • Coinsurance • Orthodontia • Glasses and contact lenses • Over-the-counter products <p><i>See IRS Publication 969 for details</i></p>	<p>Eligible out-of-pocket medical, prescription drug, dental and visions expenses for yourself and eligible your dependents</p> <p>Example of eligible expenses include:</p> <ul style="list-style-type: none"> • Deductibles • Copays • Coinsurance • Orthodontia • Glasses and contact lenses • Over-the-counter products <p><i>See IRS Publication 502 for details.</i></p>
Who's eligible? Full time employees.	<p>Employees enrolled in a High Deductible Medical Plan (HDHP).</p> <p>Employees NOT eligible:</p> <ul style="list-style-type: none"> • If your spouses has an Health Care FSA • If you are enrolled in any part of Medicare • If you are enrolled in TRICARE • Claimed as a dependent on someone else's 2024 tax return 	<p>Employees not enrolled in a Health Savings Account (HSA)</p>
How much can I contribute in 2025?	<p>Clermont County contributes to your HSA:</p> <ul style="list-style-type: none"> • \$25 per pay for Single coverage • \$50 per pay for Single + dependent coverage <p>The total maximum in 2025 including the employer contribution is:</p> <ul style="list-style-type: none"> • \$4,300 for Single Coverage • \$8,550 for Employee + Dependent coverage for 2025 <p><i>If you are 55 years of age or older, you can contribute and additional \$1,000 annually.</i></p>	\$3,300
Can I carry over any money I don't use in 2025 to the next year?	<p>Yes, the money in this account belongs to you to use now or in the future to pay for eligible health care expenses without tax implications.</p>	<p>Yes, you can roll over up to \$500 of unused funds into 2026.</p> <p><i>All incurred claims must be submitted by March 30th the following year.</i></p>
Can I change my contribution amount during the year?	<p>Yes, you can change the amount you contribute to your HSA anytime during the year. Log in to Employee Self Service (ESS) to make changes.</p>	<p>No, you can only change this election during Annual Open Enrollment or if you have a life event.</p>

Limited Purpose FSA

Eligible out-of-pocket dental and vision expenses for yourself and your eligible dependents

Examples of eligible expenses for dental and vision only include:

- Deductible
- Copays
- Coinsurance
- Orthodontia
- Glasses and contact lenses
- Over-the-counter dental and vision products

See IRS Publication 969 for details

Employees enrolled in the Health Savings Account (HSA)

\$3,300

Yes, you can roll over up to \$500 in unused funds into 2026.

All incurred claims must be submitted by March 30th the following year

No, you can only change this election during Annual Open Enrollment or if you have a life event

Dependent Care FSA

Eligible day care expenses for children under 13 or children, elders or disabled children who can't care for themselves

Example of eligible expenses include:

- Child care when you need to be at work (income must be reported by care provider)
- Preschool or nursery school
- Summer day camp

See IRS Publication 503 for details

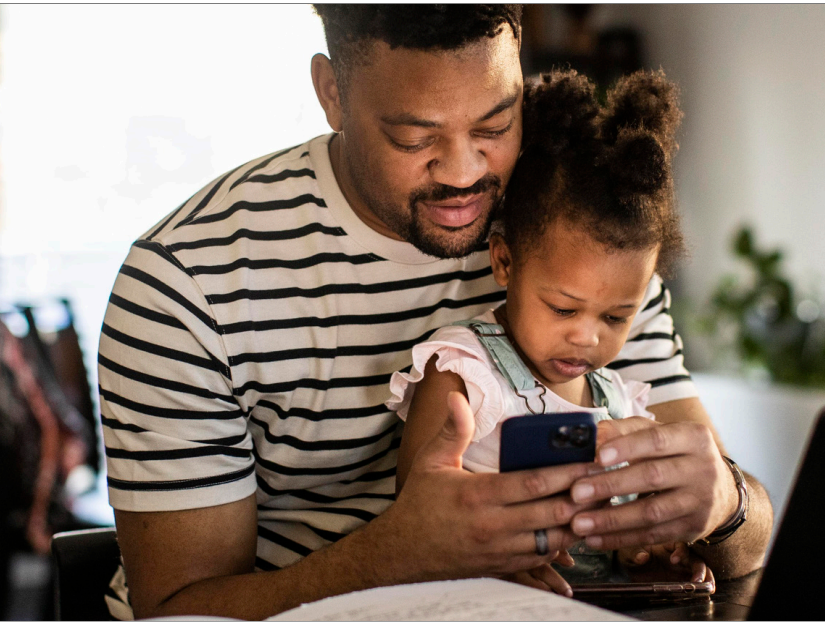
Employees who have a tax dependent under the age of 13, disabled dependents or dependent requiring eldercare.

You can set aside money, tax-free up to \$5,000 to pay for eligible day care costs (\$2,500 if married, filing separately)

No, you lose any money you don't use by December 31st each year.

All incurred claims must be submitted by March 30th the following year

Yes, you are eligible to add, stop, increase or decrease your elections. As refunds cannot be made, reduction to your election cannot be below your year-to-date contribution amount.



Prescriptions made easier

Welcome to your new pharmacy benefits

Make the most of your new pharmacy benefits from Anthem

Your pharmacy coverage is important to your whole health. Use this benefits guide to help you be your healthiest and save money, too.

Get started by registering at [anthem.com](https://www.anthem.com)

Once you receive your new member ID card, register on [anthem.com](https://www.anthem.com) to see and manage your prescriptions all in one convenient place. Through the Anthem site, 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. Use the **Price a Medication** tool in the Sydney app. It helps you find the best price for medications in your plan's network.

Find more ways to save on your prescriptions

You can save more on your prescription medicines by knowing which are covered by your plan:

- Certain preventive medicines at little or no cost to you
- Hundreds of generic and brand-name prescription medicines in every therapeutic class
- Specialty medication from our specialty pharmacy, if you have a complex or chronic condition.

Choosing a medicine on your drug list can help you pay less — especially when compared to paying out of pocket for medicines that aren't covered.

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.

When you receive your member ID card, you can see the most up-to-date list of medications for your plan. Log in at [anthem.com](https://www.anthem.com).

5 ways to save more on your prescription medications

1. Take medications on your plan's drug list.
2. Find out if there are generic or over-the-counter options.
3. Check your cost with our Price a Medication tool at [anthem.com](https://www.anthem.com).
4. Use pharmacies in your plan.
5. Order 90-day supplies of medications you take regularly.

Always check with your doctor before changing your medication.

Choose how to fill your prescriptions

Local pharmacies

Your plan includes local pharmacies at major retail chains, such as CVS, Walmart, Target, and Kroger. You'll save the most money when you use one of these pharmacies. To find a pharmacy near you:

1. Log in at [anthem.com](https://www.anthem.com).
2. Choose **Find a Pharmacy**.
3. Enter your ZIP code.

CarelonRx Pharmacy

For medications you take regularly, have your prescriptions delivered to your home with CarelonRx Pharmacy. Get started at [anthem.com](https://www.anthem.com). Shipping is always free.

Specialty pharmacy

If you have a complex or chronic condition treated with specialty medication — one that may need special handling or is given by injection or infusion — you'll need to get it through our specialty pharmacy. Your doctor will send the prescription to our specialty pharmacy for you, and it will be delivered to your home or your doctor's office if it needs to be administered by a doctor.

Preapproval (prior authorization)

Most prescriptions are filled right away when you take them to the pharmacy. There are some medicines that may require our review and approval — known as preapproval or prior authorization — before they're covered. Be confident knowing your prescription medication is safe, right for you, and covered by your pharmacy benefit.

Your doctor can start this process by calling the Pharmacy Member Services number on your member ID card or by downloading a preapproval form from our website. If we approve the request, the amount you pay for the medication depends on your plan's benefit.



We're here to help

Understanding your pharmacy benefits can help you get the most from your plan. If you have questions:

- Call us at the Pharmacy Member Services number on your member ID card.
- Visit [anthem.com](https://www.anthem.com) and send a secure message or open a live chat session.



Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. In Connecticut: Anthem Health Plans, Inc. In Indiana: Anthem Insurance Companies, Inc. In Georgia: Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. and Community Care Health Plan of Georgia, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE[®] Managed Care, Inc. (RIT), Healthy Alliance[®] Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. HMO plans are administered by Anthem Health Plans of New Hampshire, Inc. and underwritten by Matthew Thornton Health Plan, Inc. In 17 southeastern counties of New York: Anthem HealthChoice Assurance, Inc., and Anthem HealthChoice HMO, Inc. In these same counties Anthem Blue Cross and Blue Shield HP is the trade name of Anthem HP, LLC. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield, and its affiliate HealthKeepers, Inc. trades as Anthem HealthKeepers providing HMO coverage, and their service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI) underwrites or administers PPO and indemnity policies and underwrites the out-of-network benefits in POS policies offered by Compcare Health Services Insurance Corporation (Compcare) or Wisconsin Collaborative Insurance Corporation (WCIC). Compcare underwrites or administers HMO or POS policies; WCIC underwrites or administers Well Priority HMO or POS policies. Independent licensees of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.



A program focused on helping you improve your health

Introducing digital diabetes prevention coaching

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

This program can help you:



Lose
weight



Eat
healthier



Increase
activity



Sleep
better



Manage
stress

Better health is within your reach

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



Weight loss with Lark

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

24/7 coaching support

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

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

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



Learn if you are at risk for prediabetes

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



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

² Lark internal data

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

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Get care from anywhere

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

Get the care you need, virtually.

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

Care options available to you through LiveHealth Online:

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

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

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

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

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



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



Tobacco Cessation Resources with CEBCO



Ohio Tobacco Quit Line

The Ohio Tobacco Quit Line is free of charge to CEBCO members over the age of 18.

Call 1-800-QUIT-NOW to speak with a specialist to discuss assistance to help you quit tobacco. Members should state that CEBCO is their health plan when calling to take advantage of the full benefit such as:

- Five (5) sessions of one-on-one personalized coaching, along with educational materials.
- 8 weeks of Nicotine Replacement Therapy
 - Patches – Two (2) 28-day supplies
 - Gum – Two (2) shipments (100 count);
or
 - Lozenges – Two (2) boxes (72 count)



Prescription Benefits

Members wishing to try medications should make an appointment with their physician as these medications require a prescription.

Medications with a \$0 co-pay for two (2) 90-day prescriptions:

- Nicotine Inhaler
- Nicotine Nasal Spray
- Bupropion (known as Zyban)
- Varenicline (known as Chantix)

Medications that have a co-pay:

- Nortriptyline (known as Aventyl)
- Clonidine (known as Catapres)



CEBCO Members wishing to explore additional tobacco cessation resources can visit us on the web at www.cebc.org and go to the Wellness tab, then click on Tobacco Cessation.


CEBCO Rewards 200





Focus on your well-being and earn rewards up to \$200

The more activities you complete, the greater your reward


The CEBCO Rewards 200 program connects you with easy-to-use digital health and wellness tools that can help you stay your best. When you and your covered spouse complete any of the activities listed below sponsored by your employer between August 15, 2024, and June 30, 2025, you'll earn rewards to put toward electronic gift cards for select retailers. You choose the activities you'd like to complete to receive the maximum of \$200.


Activity type	Activities	Amount
 Preventive care	Have an annual preventive wellness exam or well-woman exam with your doctor	\$50
	Get an annual cholesterol test (men over 35 and women over 40) ¹²	\$25
	Have a colorectal cancer screening (ages 45 and older)	\$25
	Have a routine mammogram (women ages 40 to 74)	\$25
	Have a prostate cancer screening (men ages 55 to 69)	\$25


Activity type	Activities	Amount
 Condition management programs	Receive two annual A1c lab test (members diagnosed with diabetes) ¹	\$25
	ConditionCare: Work one-on-one with your health coach and earn rewards for completing the program ³	\$25
 Digital and wellness activities	Log in to SydneySM Health app	\$25
	Complete a health assessment and receive tailored health recommendations	\$25
	Track your steps	Up to \$50 (\$2 per 50,000 steps tracked)

Earn rewards

Here's how and when you'll earn rewards for completing the activities already mentioned.

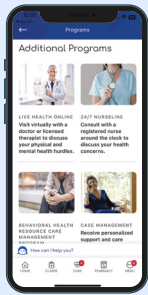
 **Preventive care:** Visit your doctor for any of the screenings or appointments listed in the chart. Your rewards are added to your account after your claim is processed, which may take up to 60 days.

 **Condition management:** Rewards are added to your account as you meet certain benchmarks or complete a program. Programs include ConditionCare (for asthma, diabetes, and heart or lung conditions) and receiving A1c lab tests if you are diagnosed with diabetes.

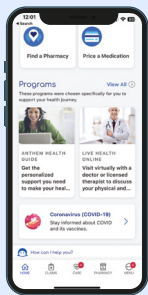
 **Digital and wellness activities:** Log in to the Sydney Health app or **anthem.com** to complete available activities, such as taking a health assessment and tracking your steps. Rewards are added to your account as activities are completed.



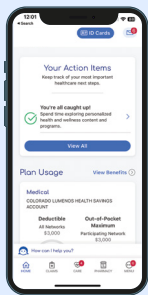
Use your rewards toward electronic gift cards for select retailers.



1 To view your rewards, open the **Sydney Health** app or go to **anthem.com**. Next, go to *My Health Dashboard*.



2 Select **My Rewards**.



3 Select **Redeem Rewards** to see how much you've earned. Use your rewards toward electronic gift cards from popular retailers, including Amazon, Gap Options (all brands), Apple®, Target, The Home Depot, T.J. Maxx, and Uber. The minimum gift card amount is set by each individual retailer. You can redeem your rewards by November 30, 2025.



Download the **Sydney Health** app by scanning this QR code with your tablet or smartphone's camera.



Do you have questions?

Log in to **anthem.com** or open the **Sydney Health** app. Then go to *My Health Dashboard* and select **My Rewards** to learn more. You can also call Member Services at the number on your health plan ID card.

1 All preventive care activities and diagnostic A1C lab test should be processed through Anthem claims in order to trigger the respective reward.

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

3 Adult members identified as moderate or high risk are eligible for ConditionCare and may receive a reward for participation in 1 of 5 ConditionCare programs and completion for 1 of 5 ConditionCare programs: chronic obstructive pulmonary disease, coronary artery disease, asthma, diabetes, and congestive heart failure. Rewards include \$20 for program participation and \$30 for program completion.

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

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

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

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

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

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

Anthem Blue Cross and Blue Shield is the trade name of Community Insurance Company. Independent licensee of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

Employee Assistance Program (EAP)



Life is filled with change and uncertainty. The responsibilities and demands on our time can be overwhelming. It happens to all of us. Whenever you or your immediate family members need help dealing with life's challenges, our Employee Assistance Program, administered by ComPsych is here to help.

You and your dependents have access to five (5) free face to face sessions or to other resources per year provided by Clermont County employees and their immediate family members through ComPsych. Services include:

Anger Management	Conflict Resolution	Drug, Gambling, Alcohol Addictions	Financial Resources	Grief Counseling
Legal Guidance	Locating Dependent or Elder Care	Personal & Mental Health	Retirement Planning	Work Related Issues

To schedule a confidential appointment: Call: 877.327.4452 TTY: 800.697.0353

Your toll-free number gives you direct, 24/7 access to a GuidanceConsultantSM, who will answer your questions and, if needed, refer you to a counselor or other resources.

Online: guidanceresources.com

App: GuidanceNowSM

Web ID: EAPCEB

Log on today to connect directly with a GuidanceConsultant about your issue or to consult articles, podcasts, videos and other helpful tools

Dental

The Clermont County dental plan will remain with **MetLife** in 2025. The group number for our dental plan is **254731**.

You have the freedom to select any dentist; but you pay less out of pocket when you choose an in-network provider. Visit www.metlife.com for a list of participating dentists. Please refer to the summary plan description for complete plan details.



Step 1:
Go to metlife.com



Step 2:
Select "Find a Dentist" next to "How can we help you?"



Step 3:
Select "PDP" or "PDP Plus" next to "Choose your network."

Enter your Zip, City or State and select the "Find a Dentist" button.

Dental Comparison

	Basic Plan	Premium Plan
	In-Network Benefits	In-Network Benefits
Individual	\$50 applies to Basic and Major Benefits only	\$50 applies to Basic and Major Benefits only
Family	\$150 applies to Basic and Major Benefits only	\$150 applies to Basic and Major Benefits only
Annual Maximum Per Per /Family	\$1,000	\$1,500
Preventive Coverage	100%	100%
Basic Coverage	80%	80%
Major Coverage (Inc. Implants)	50%	50%
Orthodontia Benefit	Not Covered	50%
Orthodontia Dependent Child(ren)	Not Covered	Covered Limited to eligible dependent children under age 19
Orthodontia Lifetime Maximum	Not Covered	\$1,500*

Please Note: It is recommended that when a course of treatment is expected to cost \$300 or more, and is of a non-emergency nature, your dentist should submit a treatment plan before he/she begins. This enables you to see what your out-of-pocket expenses will be so you are not surprised and can budget accordingly. There is also a possibility that suggested procedures may be denied, and alternative procedures approved based upon X-rays and supporting documentation.

Employee Contributions (per pay / 24 pays per year)	Basic Plan	Premium Plan
Single	\$13.78	\$16.04
EE + Spouse	\$37.80	\$44.00
EE + Child(ren)	\$34.80	\$40.49
Family	\$42.20	\$49.15

Vision

Clermont County will continue to provide vision insurance through **VSP**. To access a listing of providers (private practice and retail centers) log in to www.vsp.com.

VSP Vision	
Copay	
Routine Exams (12 months)	\$10 copay
Retinal Screening Fee	\$39 copay (no cost for those with diabetes)
Vision Materials	
Materials Copay	\$20 copay
Frame (24 months)	<ul style="list-style-type: none"> • \$180 featured frame brands allowance • \$160 frame allowance • 20% savings on the amount over your allowance • \$160 Walmart/Sam's Club frame allowance • \$90 Costco frame allowance
Lenses	<ul style="list-style-type: none"> • Single Vision, Lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children • standard progressive lenses
Lens Enhancements	<ul style="list-style-type: none"> • Premium progressive lenses (\$95-\$105 copay) • Custom progressive lenses (\$150-\$175 copay) • Average savings of 30% on other lens enhancements
Contacts (Instead of Glasses) (12 months)	<ul style="list-style-type: none"> • \$160 Allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation fee up to \$60 copay)
Eyeconic	<ul style="list-style-type: none"> • VSP online Retail option
Exclusive Member Extras	
TruHearing	<ul style="list-style-type: none"> • Save up to 60% on brand-name Hearing aids • Learn more at www.truhearing.com/vsp or call 877-396-7194
Eyeconic	<ul style="list-style-type: none"> • VSP online Retail Option for glasses, sunglasses and contacts.
Lasik Vision	<ul style="list-style-type: none"> • 20% off at The Lasik Vision Institute or \$1,000 off TLC Laser Eye Centers

Visit VSP.com and See your VSP Benefit Summary for more details

Employee Contributions
(per pay / 24 pays per year)

Single

EE + Spouse

EE + Child(ren)

Family

Vision Plan

\$2.80

\$5.88

\$6.73

\$8.07



Life and AD&D

Clermont County provides \$25,000 Basic Life and \$25,000 AD&D benefits to all eligible full-time employees at no cost to you*. The Life insurance benefit will be paid to your designated beneficiary in the event of death while covered under the plan. The AD&D benefit will be paid in the event of a loss of life or limb by accident while covered under the plan.

*Does not apply to CCDD employees – see your personnel department for details.

Voluntary Life Insurance

In addition to the employer paid Basic Life and AD&D coverage, you have the option to “buy-up” voluntary life insurance and AD&D coverage. Cost of coverage depends on the amount of coverage you elect and your current age. election, however, could be subject to medical questions and evidence of insurability. Your contributions will depend on your age and the amount of coverage you elect. If you elect voluntary employee life insurance, you also have the option to purchase coverage for your spouse and/or dependent children up to age 26.

New Hire / New Benefit Eligible

- New Hires can elect up to **3x annual base salary up to \$250,000; can apply for up to 5x annual salary (\$500k max) by** completing an EOI* (Evidence of Insurability)
- Can elect up to **\$50,000 for spouse** without EOI
- Can elect **child life up to \$20,000** without EOI
- **Spouse and/or child coverage cannot be more than the employee’s own voluntary life coverage.**

CHANGES PERMITTED DURING OPEN ENROLLMENT:

Employee

- Existing **employee** coverage can be increased **up to \$20,000** but not more than \$250,000 without an EOI
- Maximum coverage with an approved EOI application is 5x annual base salary up to \$500,000 (whichever is less)
- Employees who did not have coverage in 2023 will need to submit an EOI to pick up any amount.

Spouse

- Can increase spouse coverage **\$10,000** but not more than **\$50,000** without an EOI.
- Maximum coverage is **\$300,000 with approved EOI**, but not more than the employees’ own coverage.
- EOI is needed to add coverage for a spouse not covered in 2022 unless newly eligible for coverage, such as newlywed.
- **Dependent coverage cannot be more than the employee’s coverage.**

Children

- Can elect up to \$20,000 (increments of \$5,000)
- Maximum is \$20,000 (one policy covers all children in the family)
- **Dependent coverage cannot be more than the employee’s coverage.**

Evidence of Insurability (EOI)

You will be required to submit an EOI if requesting:

1. More than 3x your annual salary as a new hire or newly benefit eligible employee.
2. More than \$50k spousal coverage.
3. An increase during open enrollment: Of more than \$20k for yourself; or more than a \$10k increase or any amount over \$50k for your spouse

ENROLLMENT NOTES:

Enter the coverage amount in ESS – the system will calculate the per pay deduction based on age.

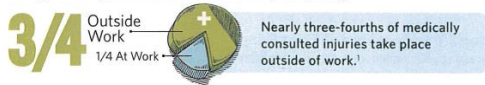
*EOI is the acronym for Evidence of Insurability (a medical information declaration).

Long Term Disability

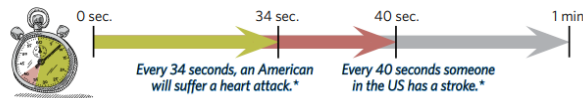
Clermont County provides you with long-term income protection through Voya Financial in the event you become unable to work due to a non-work-related illness or injury until you have 5 years of OPERS service. This benefit covers 60% of your monthly base salary up to \$5,000. Benefit payments begin after 182 days of disability. See Certificate of Coverage for benefit duration. Please see the summary plan description for complete plan details. Employees with 5 or more years of service may qualify for a similar benefit through the Ohio Public Employees Retirement System.

Supplemental Plans

Even when you live well, accidents happen. Treatment can be vital to recovery, but it can also be expensive. And if an accident keeps you away from work during recovery, the financial worries can grow quickly.



You can't predict the future, but you can plan for it. We invite you to put yourself in Good Hands with Critical Illness insurance from Allstate Benefits.



Factors that influence cancer survival!



The number of cancer survivors in the United States is increasing, and is expected to jump to nearly 19 million by 2024!

Clermont County also offers a wide selection of supplemental plans. Supplemental plans are available to all full-time employees and part-time employees who are regularly scheduled to work 20 hours or more per week.

- Allstate Cancer Coverage
- Allstate Critical Illness
- Allstate Accident Insurance
- Allstate Universal Life Insurance
- Trustmark Voluntary STD (Short-term Disability) Insurance
- Trustmark Voluntary LTD (Long-term Disability) Insurance



DID YOU KNOW?



With the loss of the primary wage earner, 1 in 3 households would have immediate trouble paying living expenses!



Common financial concerns among Americans include: the ability to afford a comfortable retirement, longevity risks, long-term care, and medical expenses.



Star Robbins & Company
Enhanced Benefits and Enrollment

For Additional information and rates, call Star Robbins Company: 800-486-7721.



Family Medical Leave Act

See employee FMLA rights Notice at the end of this document.

- Clermont County complies with the federally mandated “Family Medical Leave Act” also known as FMLA.
- FMLA is a protected leave, which provides you with job security for up to 12 weeks should you find it necessary to take a qualified personal or family medical leave.
- FMLA is only paid time off if you also have sick, vacation, personal, earned or comp time available – otherwise it is unpaid leave
- To be eligible you must have a least one year of employment with Clermont County and at least 1250 hours worked (equates to about 24 hours per week) within the 12 months immediately prior to taking FMLA protected leave.
- To ensure you are protected, complete and return all necessary documentation within the allotted time frame.

Deferred Compensation Plans

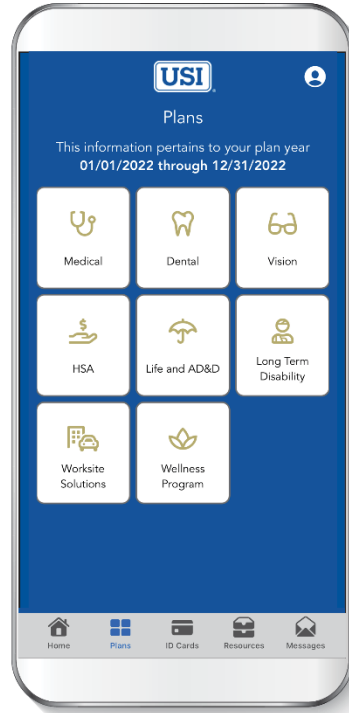
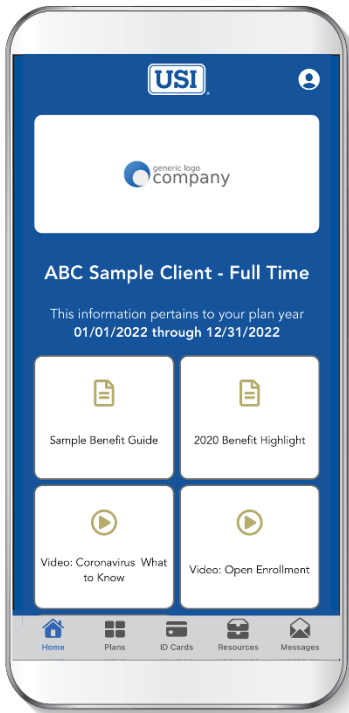
In addition to OPERS, the County offers access to participation in deferred compensation plans. These plans allow you to set aside a portion of your income on a pre-tax basis to supplement your retirement benefits. The three available plans (listed below) offer you investment options, such as a fixed rate of return, variable annuity and mutual fund plans.

1. **Ohio Public Employees Deferred Compensation Program (OPEDC)** Local Contact: **Tom Bugher: 513-829-6499** / bugher@nationwide.com; Main Phone #: 877-644-6457
2. **OCERP (Ohio County Employees Retirement Plan)** Deferred Compensation (Formerly known as CCAO) Local Contact: **Jim Carberry 513-516-4285** / jim.carberry@empower.com; To Schedule Appointment Online: <https://jim-carberry.empowermytime.com>; Main Phone #: 800-284-0444; **Website:** www.ocerp457.com
3. **Mission Square Retirement Plan** (Formerly known as ICMA-RC) Local Contact: **Ann Wilson: 202-759-7179** / awilson@missionsq.org; **Main Phone #:** 866-339-8796; Website: www.missionsq.org

COBRA Rights

The County uses COBRA Administrator Services with P&A Group. P&A Group will send out all notifications of your COBRA Rights and the COBRA Rights of your covered dependents within 30 days of your enrollment or coverage changes with the county's healthcare plans. An electronic copy is also available through the enrollment system (ESS) when you elect your benefits.

The COBRA Initial Rights document is also available on SharePoint and County's Human Resources web page: and published in the medical summary plan description documents. If you have questions regarding COBRA coverage, please contact the Benefits Office: 732-7981.



Download **MyBenefits2GO** from the app store and access your benefits details and contact information when you need it.

Clermont County

Enter this code when prompted:

G28511

Call the Benefit Resource Center (“BRC”),
We’re Here To Help!

We speak insurance. Our Benefits Specialists can help you with:

- Deciding which plan is the best for you
- Benefit plan & policy questions
- Eligibility & claim problems with carriers
- Information about claim appeals & process
- Allowable family status election changes
- Transition of care when changing carriers
- Claim escalation, appeal & resolution



Benefit Resource Center

BRCMidwest@usi.com | Toll Free: 855-874-0829
Monday through Friday 8:00am to 5:00pm Eastern & Central
Standard Time

Important Legal Notices Affecting Your Health Plan Coverage

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For 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. Therefore, the following deductibles and coinsurance apply:

Premium Copay: Deductible: \$2,000/\$4,000 Coinsurance: 80/20%

Basic Copay: Deductible: \$5,000/\$10,000 Coinsurance: 90/10%

HDHP: Deductible: \$3,300/\$6,000 Coinsurance: 90/10%

NEWBORNS ACT DISCLOSURE – FEDERAL

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

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment 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).

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

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact the person listed at the end of this summary.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.
- Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage

If applicable, you may continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants.

No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan reviewed and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 per day, until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

CONTACT INFORMATION

Questions regarding any of this information can be directed to:

Yvonne Smith

Employee Benefits Coordinator

101 E. Main Street

Batavia, Ohio 45103

513-732-7981

ysmith@clermontcountyohio.gov

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.***

Contact information for questions or complaints is available at the end of the notice.

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

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

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

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 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, usually within 60 days.

Request confidential communication

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.

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 up to 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 at the end of this notice.
- 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/hipaa/filing-a-complaint/index.html.
- 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.

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.

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.

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/hipaa/for-individuals/guidance-materials-for-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.

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/hipaa/for-individuals/guidance-materials-for-consumers/index.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 (if applicable), and we will mail a copy to you.

Other Instructions for Notice

- Effective Date of this Notice: January 1, 2025
- Yvonne Smith, Employee Benefits Coordinator, ysmith@clermontcountyohio.gov,
Phone: 513-732-7981

Important Notice from Clermont County About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Clermont County 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. Clermont County has determined that the prescription drug coverage offered by the Anthem Plans for the plan year 2025 are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered **Creditable Coverage**. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, the following options may apply:

- You may stay in the Anthem Plans and not enroll in the Medicare prescription drug coverage at this time. You may be able to enroll in the Medicare prescription drug program at a later date without penalty either:
 - During the Medicare prescription drug annual enrollment period, or
 - If you lose Anthem Plans creditable coverage.
- You may stay in the Anthem Plans and also enroll in a Medicare prescription drug plan. The Anthem Plans will be the primary payer for prescription drugs and Medicare Part D will become the secondary payer.
- You may decline coverage in the Anthem Plans and enroll in Medicare as your only payer for all medical and prescription drug expenses. If you do not enroll in the Anthem Plans, you are not able to receive coverage through the plan unless and until you are eligible to reenroll in the plan at the next open enrollment period or due to a status change under the cafeteria plan or special enrollment event.

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

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

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Clermont County changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	01/01/2025
Name of Entity/Sender:	Clermont County
Contact--Position/Office:	Yvonne Smith, Employee Benefits Coordinator
Address:	101 E. Main Street, Batavia, OH 45103
Phone Number:	513-732-7981



Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). 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 Employment-Based 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 9.12%¹ 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 9.12% of the employee's household income.²

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 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.

¹ Indexed annually; see <https://www.irs.gov/pub/irs-drop/rp-22-34.pdf> for 2023.

² 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.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023, and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

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, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023, and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your 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:

Name of Entity/Sender:	Clermont County
Contact--Position/Office:	Yvonne Smith, Employee Benefits Coordinator
Address:	101 E. Main Street, Batavia, OH 45103
Phone Number:	513-732-7981

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Clermont County	4. Employer Identification Number (EIN) 31-6000067	
5. Employer address 101 E. Main Street	6. Employer phone number 513-732-7981	
7. City Batavia	8. State OH	9. ZIP code 45103
10. Who can we contact about employee health coverage at this job? Yvonne Smith, Employee Benefits Coordinator		
11. Phone number (if different from above)	12. Email address Ysmith@clermontcountyohio.gov	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
 All employees. Eligible employees are:

Employees working 30+ hours per week

- Some employees. Eligible employees are:

- With respect to dependents:
 We do offer coverage. Eligible dependents are:

Dependents of eligible employees

- We do not offer coverage.

- If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, [HealthCare.gov](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.

Important Contacts

Have Questions? Need Help?

Clermont County is excited to offer access to the USI Benefit Resource Center (BRC), which is designed to provide you with a responsive, consistent, hands-on approach to benefit inquiries. Benefit Specialists are available to research and solve elevated claims, unresolved eligibility problems, and any other benefit issues with which you might need assistance. The Benefit Specialists are experienced professionals and their primary responsibility is to assist you.

The Specialists in the Benefit Resource Center are available Monday through Friday 8:00am to 5:00pm Eastern & Central Standard Time at 855-874-0829 or via e-mail at BRCMidwest@usi.com. If you need assistance outside of regular business hours, please leave a message and one of the Benefit Specialists will promptly return your call or e-mail message by the end of the following business day.

Carrier Customer Service

Additional information regarding benefit plans can be found on www.hr.dermontcountyohio.gov. Please contact Human Resources to complete any changes to your benefits that are not related to your initial or annual enrollment.

	CARRIER	PHONE NUMBER	WEBSITE
Medical PPO	Anthem BlueCross BlueShield	See Member ID card	www.anthem.com
Prescription Coverage	Carelon Rx	833-419-0530	www.carelonrx.com
Dental PPO	MetLife	800-942-0854	www.metlife.com
Vision	VSP	800-877-7195	www.VSP.com
Life, AD&D, LTD	Voya Financial	800-955-7736	www.voya.com
Spending Accounts	Chard Snyder	888-993-4646	www.chard-snyder.com
Voluntary Critical Illness	Allstate Insurance Company	800-486-7721	www.starrobbins.com
Voluntary Cancer	Allstate Insurance Company	800-486-7721	www.starrobbins.com
Accident	Allstate Insurance Company	800-486-7721	www.starrobbins.com
Short Term Disability (STD)	Trustmark	800-486-7721	www.starrobbins.com
Long Term Disability (LTD)	Trustmark	800-486-7721	www.starrobbins.com
Employee Assistance Program (EAP)	ComPysch	877-327-4452	www.guidanceresources.com

This brochure summarizes the benefit plans that are available to Clermont County eligible employees and their dependents. Official plan documents, policies and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits program. If there is any conflict, the official documents prevail. These documents are available upon request through the Human Resources Department. Information provided in this brochure is not a guarantee of benefits.