HEALTH
INSURANCE

CLERMONT
COUNTY OHIO

2024 BENEFITS GUIDE

Inside the Guide

Welcome	3
Enrollment & Eligibility	4-5
HealthCare Benefits	6
Health Savings Account (HSA)	7
Flexible Spending Account (FSA)	8
2024 HealthCare Benefit Rates	9
Medical	10
MagellanRx	11-13
Dental	14-16
Vision	17-19
MyBenefits2GO Mobile App	20
Benefit Resource Center	21
Ohio Medicaid	22
Christ Hospital Orthopedic Program	23
Life and AD&D	24
Long Term Disability	25
Supplemental Plans	25
Employee Assistance Program (EAP)	25
Hearing Aid & Genetic Testing	26
Real Appeal	27
Quit for Life	27
Family Medical Leave Act (FMLA)	28
Deferred Compensation Plans	28
COBRA Rights	28
Important Contacts	29
Required Annual Legal Notices	30

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. Through our benefits programs we strive to support the needs of our employees and their dependents by providing a benefit package that is easy to understand, easy to access and affordable for all our employees. This brochure will help you choose the type of plan and level of coverage that is right for you.

You can also view overviews of our benefit plans by accessing our website, www.hr.clermontcountyohio.gov or on the Mobile App. Download in the App Store or Google Play Store and enter code G28511 in the app to access your benefit highlights.

Sincerely,

The benefits illustrated are available to the majority of Clermont County employees and based on policies approved by the Board of Commissioners.

Employees within the office of another Elected Official, or part of a Collective Bargaining Group (union): Some of the information herein may not apply to you due to specific conditions included in your individual agreement and/or department policies. Please refer to your Department Head or Collective Bargaining agreement for specific information 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:

- Keep same health insurance coverage; add, change, or delete coverage.
- Add, or drop dependents from coverage.
- Elect FSA benefits, a new enrollment is required each plan year to continue coverage.
- Increase your existing voluntary life, spouse life and/or child life. NOTE: new coverage requires vendor approval.

New Hires & Newly Eligible

Coverage begins after 30 days of full-time employment. Ex.: If your hire date were 03/01/2024, your benefits would be effective 03/31/2023 (this is your "eligibility date").

- In the week following your hire date, you will receive an email notification that the system is set up to accept your benefit selections.
- 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. In most instances, a qualifying event must be reported to the employer within 30 days of the actual event (Medicare/Medicaid/Healthy-Start eligibility is extended to 60 days).

Reporting A "QE"

- In ESS/Benefits: Click on the "life events" link at the top of the page; select the appropriate qualifying event from the drop-down box and enter the event date.
- Send your supporting documentation to the Employee Benefits Office;
- You will receive an email stating "an event has been created for you", enter your changes ASAP.

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:

CORE BENEFITS: 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.
- Coverage through the county ends at the end of the month in which the child reaches age 26.

Pre-Tax Deductions:

Clermont County participates in the "IRS Section 125 Cafeteria Plan:

- Section 125 allows employers to take out deductions for your medical, dental, vision, FSA and/or HSA before assessing your payroll tax each pay period-this lowers your payroll (income tax).
- Section 125 rules prohibit mid-year changes to pre-tax benefits* except for a "Qualifying Event" (QE)
  HSA (health savings account) is the exception to this section 125 rule and allows changes at any time.
- Section 125 does not apply to the county Voluntary Life and Supplemental Benefits – these are paid "Post-tax" so this can be reduced or dropped at any time during the year. Vendor contract terms restrict new elections to the "new hire" and "open enrollment" period.

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 (i.e. marriage, divorce, death of spouse, legal separation)
- Change in number of dependents (i.e. birth, adoption, death of dependent, ineligibility due to age)
- Change in employment or job status (spouse loses job, etc.)

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: Yvonne Smith, Benefits Coordinator, Human Resources.

Healthcare Benefits

Funding for government entities has disadvantages when compared to private employers, mainly because "for profit" businesses can simply increase the cost of their product to cover their operating costs, including wages and benefits. Government entities have no "profit-centers" so must budget based solely on expected income from taxes, federal & state funding, grants, etc.

Medical Coverage: UHC "Choice Plus" Network www.myuhc.com

Copay Plan

A "Traditional type" plan with set copays for in-network office & specialist visits, prescription drugs, etc. "Tier 1" providers provide the best value for your money on this plan. You could end up paying double copays if you use certain types of specialists without the "Tier 1" designation.

In-Network Benefits:

- Primary Care Physician: $0 copay. Some treatments during the OV may apply to your deductible.
- Other copays: "Virtual Dr.": $0; Urgent Care visits: $25; ER Visits: $250 + 20% coinsurance
- Deductible: $2,000 one person / $4,000 combined family
- Maximum out-of-pocket: $5,500 one person; $11,000 maximum for combined family.

HDHP with HSA Plan:

Has lower per pay deductions when compared to the Copay plan. It is a plan that you can easily budget for- the most you would have to pay out-of-pocket in a year is the deductible. Its best feature is that you can pair it with a Health Savings Account (HSA), to which the County contributes, and employees can deposit additional funds. Participants can select a Limited FSA for dental and vision out-of-pocket expenses. The IRS has increased the embedded minimum deductible for 2024 to $3,200 / $6,400.

In-network Benefits:

- Deductible: $3,200 one person / $6,000 combined family.
- Coinsurance 90/10%: Pays 90% of claims after deductible, up to the maximum out-of-pocket.
- Maximum out-of-pocket: $4,000 one person / $8,000 combined family.

HSA/FSA Benefits

What are HSA and FSA's? How can they benefit you?

Participation in one or more of these accounts will allow you to set aside some of your income on a pre-tax basis to pay for healthcare and/or daycare expenses not covered by your other benefit plans. How they work: You elect and contribute to one or both accounts; these contributions are taken from your paycheck before taxes are calculated. By participating in this type of plan, not only do you reduce your taxable income, but you also have money readily available to pay healthcare and/or dependent care expenses using tax-free dollars.

Health Savings Account (HSA)

A health savings account is an account that you can use to pay medical and prescription expenses.

To be an eligible individual and qualify to contribute to an HSA, you must meet the following requirements:

- You must be covered under an HDHP (high deductible medical plan) on the first day of the month.
- You must not be covered by another health coverage (a non-qualified medical plan that is not an HSA or a spouse's full purpose FSA)
- You must not be enrolled in any part of Medicare
- You must not be claimed as a dependent on someone else's tax return.

- **There are IRS limits to how much you can contribute to your HSA every year.**
- **The 2024 Limits are $4,150/employee only and $8,300/family.**
- **Clermont County contributes to your HSA.**

- **For 2024: Clermont County contributes $25 per pay to your single HSA or $50 per pay to any other tier.**

You must subtract the County contribution from the IRS maximum allowed.

- Those 55 years and older and not enrolled in Medicare can contribute an additional $1,000 "catch-up each year
- You can choose to contribute tax-free money via payroll deductions up to the federal maximums including what both you and your employer contribute.

Flexible Spending Accounts (FSA)

The Flexible Spending Account (FSA) plan with Chard, Snyder and Assoc., Inc. (TPA) allows you to set aside pre-tax dollars to cover qualified expenses you would normally pay out of your pocket with post-tax dollars. The plan is comprised of a health care spending account and a dependent care account. You pay no federal or state income taxes on the money you place in an FSA.

How an FSA works:

- Choose a specific amount of money to contribute each pay period, pre-tax, to one or both accounts during the year.
- The amount is automatically deducted from your pay at the same level each pay period.
- As you incur eligible expenses, you may use your flexible spending debit card to pay at the point of service OR submit the appropriate paperwork to be reimbursed by the plan.

Important rules to keep in mind:

- The IRS has a strict "use it or lose it" rule. If you do not use the full amount in your FSA, you will lose any remaining funds.
- Once you enroll in the FSA, you cannot change your contribution amount during the year unless you experience a qualifying life event.
- You cannot transfer funds from one FSA to another.
- Maximum rollover at year end is $500 - HealthCare FSA only.
- **Any balance remaining in your account at the end of your employment is forfeited.**

Please plan your FSA contributions carefully, as any funds over $500 in HealthCare FSA not used by the end of the year will be forfeited. Re-enrollment is required each year.

- No rollover available for dependent care accounts.
- **Money left in account at termination or retirement is forfeited**.

2024 FSA Contribution Limit	
Health Care Full and Limited FSA	**$3,200**
Dependent Care FSA	**$5,000**

2024 PER PAY BENEFIT DEDUCTIONS

2024 HealthCare Plans ***(per pay / 24 pays per year)***

MEDICAL COPAY	**COUNTY BENEFIT CREDIT**	**EMPLOYEE** *(Before PCP Credit)*
SINGLE	$327.73	$44.03
EE + SPOUSE	$642.38	$135.60
EE + CHILD(REN)	$535.61	$109.68
FAMILY	$1,020.35	$196.98

MEDICAL HDP / HSA	**COUNTY BENEFIT CREDIT**	**EMPLOYEE** *(Before PCP Credit)*	**COUNTY HSA CONTRIB.**
SINGLE	$265.64	$30.00	$25.00
EE + SPOUSE	$519.51	$98.96	$50.00
EE + CHILD(REN)	$432.91	$79.14	$50.00
FAMILY	$825.00	$141.57	$50.00

DENTAL	**Basic Plan**	**Premium Plan**
SINGLE	$13.00	$15.13
EE + SPOUSE	$35.66	$41.51
EE + CHILD(REN)	$32.83	$38.20
FAMILY	$39.81	$46.37

VISION	
SINGLE	$2.80
EE + SPOUSE	$5.88
EE + CHILD(REN)	$6.73
FAMILY	$8.07

Spousal Surcharge: **$50 per pay** (in addition to selected plan rate) for employees electing spousal coverage through the county when the spouse has coverage available through their own employer.

Tobacco User Rates: $25.00 upcharge per pay (in addition to selected plan rate)

HSA County Contribution Per Pay: Employee Only: $25; w/Dependent Coverage: $50

County Paid Life Insurance; Amount $25,000: $0.13 per $1,000 (= $3.25 per employee).
County Paid LTD Insurance: $0.137 per $100 (X annual base salary)

Medical

	UnitedHealthcare Medical Copay		UnitedHealthcare Medical HDHP/HSA	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Annual Deductible				
Individual / Family	$2,000 / $4,000	$4,000 / $8,000	$3,200 / $6,000	$6,000 / $12,000
Coinsurance *(after deductible)*	80%	60%	90%	70%
Maximum Out-of-Pocket				
Individual / Family	$5,500 / $11,000	$8,000 / $16,000	$4,000 / $8,000	$10,000 / $20,000
Physician Office Visit			AFTER DEDUCTIBLE	
Primary Care	No Charge	60%	90%	70%
Virtual Visit	No Charge	60%	90%	70%
Specialty Care	$50 copay, Designated Network*. $100 copay, Network*	60%	90%	70%
Preventive Care	No charge	60%	No charge	70%
Diagnostic Services			AFTER DEDUCTIBLE	
Outpatient Radiology and Lab	80%	60%	90%	70%
Urgent Care Facility	$25 copay*	60%	90%	70%
Emergency Room Facility Charges	$250 copay per visit, 20% coinsurance*		90%	90%
Inpatient & Outpatient Facility	80%	60%	90%	70%
Elixir RX Retail Pharmacy (30 Day Supply)			AFTER DEDUCTIBLE	
Generic (Tier 1)	$15 copay	Not covered	90%	Not covered
Preferred (Tier 2)	$50 copay	Not covered	90%	Not covered
Non-Preferred (Tier 3)	$70 copay	Not covered	90%	Not covered
Preferred Specialty (Tier 4)	25% coinsurance	Not covered	90%	Not covered
Elixir RX Mail Order Pharmacy (90 Day Supply)			AFTER DEDUCTIBLE	
Generic (Tier 1)	$30 copay	Not covered	90%	Not covered
Preferred (Tier 2)	$100 copay	Not covered	90%	Not covered
Non-Preferred (Tier 3)	$140 copay	Not covered	90%	Not covered
Preferred Specialty (Tier 4)	25% coinsurance	Not covered	90%	Not covered

*Deductible does not apply

Magellan Rx MANAGEMENT℠

Getting the Most Out of Your Pharmacy Benefits

Providing you with the tools and resources to help you make better drug therapy decisions

Dedicated Partner

As your pharmacy benefit manager, Magellan Rx Management is dedicated to giving you the best information and resources to help you make better healthcare decisions to lead a healthy, vibrant life. Our wide range of prescription benefit programs emphasize quality and cost-effective solutions that lead to better drug therapy choices.

Maximize Your Benefit

Your decisions play a key role in the effectiveness of your prescription benefit. Here are a few tips to help you maximize your benefit.

Request Generics

- Generic medications provide quality, cost-effective alternatives to brand medications and may help reduce costs to you and your plan.
- Ask your local pharmacy if they offer any low-cost generic programs. Use your prescription benefit card to process your order and receive the lower priced alternative, whether it is the pharmacy's generic program price or your copay.

Take Your Medications As Directed

- Taking medications exactly as prescribed is one of the most important things you can do to enhance your health and prevent medical complications.
- Missing doses, stopping medication early or swapping medications with other people can lead to serious problems that may negatively impact health outcomes.

Take Advantage of Over-The-Counter (OTC) Products

- Some medications that used to only be available by prescription (e.g., Claritin®, Prilosec®, and Zyrtec®) are now available over-the-counter without a prescription.
- Ask your doctor if any OTC alternatives are available to effectively treat your condition. Switching to an OTC product could save both you and your plan money.

Our Commitment

Your prescription benefit program is designed to help you and your eligible dependents obtain prescription medications conveniently and at reasonable prices. We are committed to:

- Helping you achieve the best possible health outcomes
- Promoting the use of safe, cost-effective and clinically appropriate medications
- Helping you save money and providing convenient access to your prescription medications

Now available on Apple and Google:

The Magellan Rx Mobile App

Download the Magellan Rx app today and get access to:

- Real-time prescription updates
- Notifications for prescription refills
- Alerts for severe drug-drug interactions
- Drug information and education
- Cost management tools
- Pharmacy claims history

These tools are also available online at **magellanrx.com/member/login**.

Questions? Visit **magellanrx.com** or contact customer service 24/7 at **800.424.0472** with any questions about your prescription benefit.

magellanrx.com

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Magellan Rx MANAGEMENT℠

Understanding Your Prescription Benefit Program

Providing you with the tools and resources to help you make better drug therapy decisions

Your Prescription Benefit Plan through Magellan Rx Management

Magellan Rx Management is your pharmacy benefit manager. Magellan Rx is dedicated to giving you the best service and resources to help you and your family make better healthcare decisions to lead more healthy, vibrant lives.

Using Your Prescription Drug Card at Retail Pharmacies
You will receive a prescription card from your employer. Please present your new prescription card along with your prescription to any of our 68,000+ retail pharmacies every time you fill your prescription. You can access a participating pharmacy list at www.magellanrx.com.

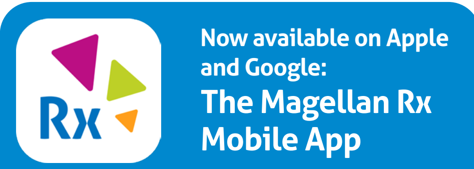
Home Delivery by Magellan Rx Pharmacy
With home delivery, you may be able to receive up to a 90-day supply of your maintenance medication(s) at a lower price. Just ask your doctor to write two prescriptions: one for a 30-day supply to get you started (to be filled at your local pharmacy), and one for a 90-day supply, plus additional refills (to be filled by mail). Next, you may either:

- Ask your doctor to **e-prescribe** or **fax** your prescription to 1.888.282.1349.
  - Faxed prescriptions may only be sent by a doctor's office and must include patient information and diagnosis.
  - Please note: For prompt delivery, please provide your payment information by mailing in your completed order form or by calling 1.800.424.0472.
- **Mail** us your 90-day prescription and completed order form (available online) with payment to Magellan Rx Pharmacy, P.O. Box 620968, Orlando, FL 32862.

Prior Authorization/Step Therapy

Your prescription benefit program may have a prior authorization or step therapy process for certain medications. Please see the formulary lookup tool at www.magellanrx.com for more information.

- *Prior authorization* is a requirement that your physician obtain approval from your health plan to prescribe a specific medication for you.
- *Step therapy* is when your prescription benefit requires you to try another medication prior to starting the medication your physician prescribed.



Now available on Apple and Google:
The Magellan Rx Mobile App

Download the Magellan Rx app today and get access to:

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- Cost management tools
- Pharmacy claims history

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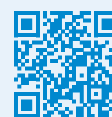

Check out **this video** to learn more about the Magellan Rx mobile app.

To see the member portal tools and features, **watch here**.

Questions? Visit **magellanrx.com** or contact customer service 24/7 at **800.424.0472** with any questions about your prescription benefit.

magellanrx.com

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Magellan Rx MANAGEMENT℠

The Magellan Rx Mobile App

On-hand prescription drug management tools

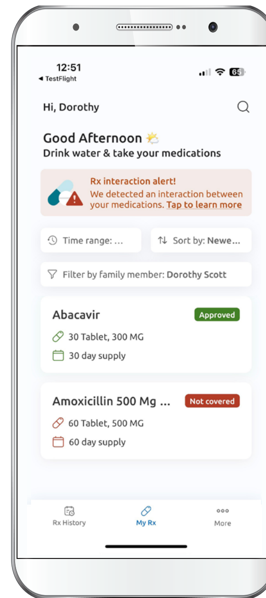
The Magellan Rx app can help you understand and maximize your prescription drug benefits. Get access to real-time updates, medication information and drug cost savings tools in the palm of your hand!

Check the status of your prescriptions

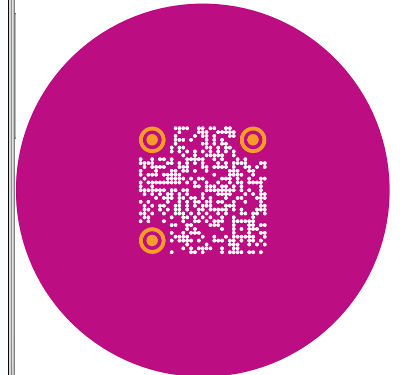
Price a drug

Get detailed prescription information

View Rx Claims History



Search for "Magellan Rx" in your app store to download the app!



Coming Soon!

- Data sharing between plan dependents and cardholder
- Mail order management
- Detailed prescription and prior authorization
- Covered prescription alternatives

Questions?

Contact Magellan Rx Customer Service 24/7 at 1.800.424.0472 with any questions about your prescription benefits.

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Dental

The Clermont County dental plan will be changing administrators in 2024 to **MetLife**. The new 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.

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 depedent 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.

Metropolitan Life Insurance Company

PDP Plus Network

Employee Name

Employee ID

Clermont County

Group Name

254731

Group Number

This card is not a guarantee of coverage or eligibility. See reverse side for important plan information.

metlife.com/mybenefits

- Locate a participating dentist.
- Verify eligibility and plan design information.
- Review claim status and claim history for your entire family.
- View and print processed claims with one click.
- Obtain claims forms and educational information (including interactive risk assessment).
- Get instant answers to Frequently Asked Questions.
- Access trained customer service representatives.

1-800-942-0854

- Virtually 24 hours a day, 7 days a week to confirm eligibility, order claim forms or request dentist directories
- Monday-Friday, 8 a.m. to 11 p.m., Eastern Time, to speak with a live customer service representative
- MetLife Dental Claims P.O. Box 981282 El Paso, TX 79998-1282
- For International Dental Travel Assistance call 1-312-356-5970 (collect)

00760522

Find a Dental Provider

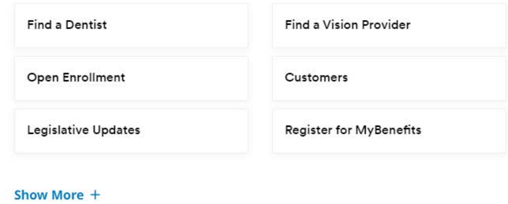
With MetLife Dental insurance, you can choose from thousands of general dentists and specialists nationwide. You can find the names, addresses, languages spoken and phone numbers of participating dentists by searching our online **Find a Dentist** directory.

Step 1:

Go to metlife.com

Step 2:

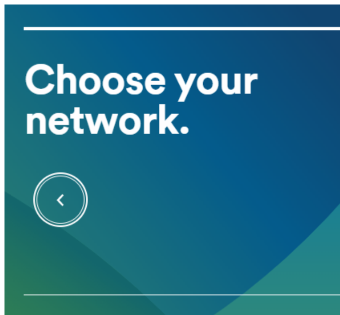
Select "Find a Dentist" next to "How can we help you?"

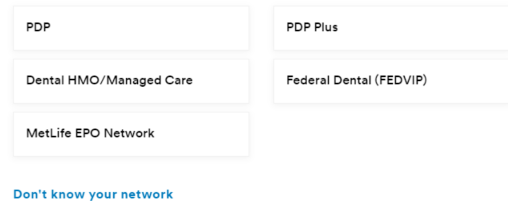


Step 3:

Select "PDP" or "PDP Plus" next to "Choose your network."

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





Like most group benefit programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, waiting periods, reductions, limitations and terms for keeping them in force. Please contact MetLife or your plan administrator for complete details.

Metropolitan Life Insurance Company | 200 Park Avenue | New York, NY 10166

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Dental Insurance

Coverage that can help make it easier to visit a dentist and can help lower your dental costs.

Clermont County

Network: PDP Plus

	Plan option 1 Buy Up Plan		Plan option 2 Core Plan	
	In-Network[1] % of Negotiated Fee[2]	Out-of-Network[1] % of R&C Fee**	In-Network[1] % of Negotiated Fee[2]	Out-of-Network[1] % of R&C Fee**
Coverage Type				
Type A: Preventive (cleanings, exams, X-rays)	100%	100%	100%	100%
Type B: Basic Restorative (fillings, extractions)	80%	80%	80%	80%
Type C: Major Restorative (bridges, dentures)	50%	50%	50%	50%
Type D: Orthodontia	50%	50%	Not covered	Not covered
Deductible†				
Individual	$50	$50	$50	$50
Family	$150	$150	$150	$150
Annual Maximum Benefit				
Per Person	$1,500	$1,500	$1,000	$1,000
Orthodontia Lifetime Maximum				
Per Person***	$1,500	$1,500	N/A	N/A

Child(ren)'s eligibility for dental coverage is from birth up to age 26.

[1] "In-Network Benefits" refers to benefits provided under this plan for covered dental services that are provided by a participating dentist. "Out-of-Network Benefits" refers to benefits provided under this plan for covered dental services that are not provided by a participating dentist.
[2]Negotiated fees refer to the fees that participating dentists have agreed to accept as payment in full for covered services, subject to any copayments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.
**R&C fee refers to the Reasonable and Customary (R&C) charge, which is based on the lowest of (1) the dentist's actual charge, (2) the dentist's usual charge for the same or similar services, or (3) the charge of most dentists in the same geographic area for the same or similar services as determined by MetLife.
†Applies only to Type B & C Services.
*** Orthodontia excluded for adults. Available for dependent children up to age 19.

List of Primary Covered Services & Limitations*

The service categories and plan limitations shown represent an overview of your Plan Benefits. This document presents the majority of services within each category but is not a complete description of the Plan.

Plan Type	Plan Option 1: Buy Up Plan How Many/How Often	Plan Option 2: Core Plan How Many/How Often
Type A — Preventive		
Prophylaxis (cleanings)	Two per calendar year	Two per calendar year
Oral Examinations	Two exams per calendar year	Two exams per calendar year
Topical Fluoride Applications	One fluoride treatment per calendar year for dependent children up to his/her 18th birthday	One fluoride treatment per calendar year for dependent children up to his/her 18th birthday

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DN-ANY-PPO-DUAL

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.

Vision Comparison

	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)	• $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	• Single Vision, Lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children
Lens Enhancements	• standard progressive lenses • 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)	• $160 Allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation fee up to $60 copay)
Eyeconic	• VSP online Retail option
Exclusive Member Extras	
TruHearing	• Save up to 60% on brand-name Hearing aids • Learn more at www.truhearing.com/vsp or call 877-396-7194
Eyeconic	• VSP online Retail Option for glasses, sunglasses and contacts.
Lasik Vision	• 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	

A LOOK AT YOUR VSP VISION COVERAGE

SEE HEALTHY AND LIVE HAPPY WITH HELP FROM CLERMONT COUNTY AND VSP.

Enroll in VSP® Vision Care to get personalized care from a VSP network doctor at low out-of-pocket costs.

VALUE AND SAVINGS YOU LOVE.

Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras for additional savings.

PROVIDER CHOICES YOU WANT.

It's easy to find a nearby in-network doctor. Maximize your coverage with bonus offers and savings that are exclusive to Premier Program locations—including thousands of private practice doctors and over 700 Visionworks retail locations nationwide.

Visionworks

QUALITY VISION CARE YOU NEED.

You'll get great care from a VSP network doctor, including a WellVision Exam®—a comprehensive exam designed to detect eye and health conditions.

USING YOUR BENEFIT IS EASY!

Create an account on **vsp.com** to view your in-network coverage, find the VSP network doctor who's right for you, and discover savings with exclusive member extras. At your appointment, just tell them you have VSP.

GET YOUR PERFECT PAIR

EXTRA $20 TO SPEND ON FEATURED FRAME BRANDS*

bebe CALVIN KLEIN COLE HAAN FLEXON LACOSTE NINE WEST

SEE MORE BRANDS AT **VSP.COM/OFFERS**.

\+

UP TO 40% SAVINGS ON LENS ENHANCEMENTS

Enroll today.

Contact us: **800.877.7195** or **vsp.com**

YOUR VSP VISION BENEFITS SUMMARY

CLERMONT COUNTY and VSP provide you with an affordable vision plan.

PROVIDER NETWORK:

VSP Choice

EFFECTIVE DATE:

01/01/2022

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
	YOUR COVERAGE WITH A VSP PROVIDER		
WELLVISION EXAM	• Focuses on your eyes and overall wellness	$10	Every calendar year
PRESCRIPTION GLASSES		$20	See frame and lenses
FRAME	• $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	Included in Prescription Glasses	Every other calendar year
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	Included in Prescription Glasses	Every calendar year
LENS ENHANCEMENTS	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 30% on other lens enhancements	$0 $95 - $105 $150 - $175	Every calendar year
CONTACTS (INSTEAD OF GLASSES)	• $160 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every calendar year
PRIMARY EYECARE℠	• Retinal screening for members with diabetes • Additional exams and services for members with diabetes, glaucoma, or age-related macular degeneration. • Treatment and diagnoses of eye conditions, including pink eye, vision loss, and cataracts available for all members. • Limitations and coordination with your medical coverage may apply. Ask your VSP doctor for details.	$0 $20 per exam	As needed
EXTRA SAVINGS	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/offers for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam. **Routine Retinal Screening** • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam **Laser Vision Correction** • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		
YOUR MONTHLY CONTRIBUTION	$5.60 Member only $11.76 Member + 1 $13.46 Member + children $16.14 Member + family		

YOUR COVERAGE WITH OUT-OF-NETWORK PROVIDERS

Get the most out of your benefits and greater savings with a VSP network doctor. Call Member Services for out-of-network plan details.

Coverage with a retail chain may be different or not apply. Log in to **vsp.com** to check your benefits for eligibility and to confirm in-network locations based on your plan type. VSP guarantees coverage from VSP network providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business.

Log in to **vsp.com** to find an in-network provider based on your plan type.

*Only available to VSP members with applicable plan benefits. Frame brands and promotions are subject to change. Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details.

Classification: Restricted

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VSP, VSP Vision Care for life, Eyeconic, and WellVision Exam are registered trademarks, VSP Diabetic Eyecare Plus Program is servicemark of Vision Service Plan. Flexon is a registered trademark of Marchon Eyewear, Inc. All other brands or marks are the property of their respective owners.

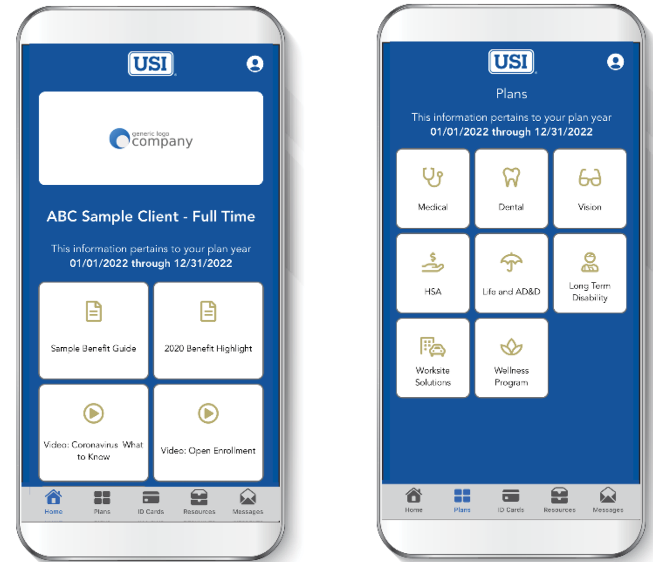
Benefits Information When You Need It Most

Clermont County

FIND IT IN THE APP STORE

Search for '**MyBenefits2GO**' and download our free app.

Enter this code when prompted: **G28511**



HIGHLIGHTS OF THE MyBenefits2GO APP

- Access benefits information on the go
- Convenient contact information for Carriers and HR
- Organized plan information in one place
- View the most updated plan information
- Store your ID cards in the app

MyBenefits2GO: FREE MOBILE BENEFITS APP FOR ANDROID AND IPHONE

The MyBenefits2GO app gives you on-the-go access to your benefit and insurance policy details, HR contact information and more!

The app is a quick and simple way for you and your enrolled dependents to access benefit summaries and other important information about our group plans. Store photos of ID cards in the app and easily locate carrier and HR contact information—all in one place. The MyBenefits2GO app is free for iPhone and Android.

Getting In Touch

The app provides employees and their enrolled dependents single-point contact information for benefits resources and insurance carriers.

Lightening Wallets

The app allows you to store and share images of your ID cards, freeing up space and giving you access when you need it.

Keeping Up-to-Date

The app automatically connects you with the most updated plan information and allows for message reminders from your employer.

Staying Organized

The app gives you access to benefit plan information and ID cards—all in one place.

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USI

Contact the Benefit Resource Center ("BRC")!

Toll Free: 855-874-0829

BRCMidwest@usi.com

Our Benefits Specialists can assist you Monday through Friday, 8am to 5pm EST & CST

Children, Families, and Pregnant Women

Ohio Medicaid offers three programs for children, pregnant women and families with limited income to get health care.

Children, Families, and Pregnant Women

Once eligible for Medicaid, each child (birth through age 20) will have access to an important group of services known as Healthchek.

Healthy Start

Healthy Start includes Medicaid and CHIP programs.

The Medicaid program is available to:

- Insured or uninsured children (up to age 19) in families with income up to 156% of the federal poverty level.
- Pregnant women in families with income up to 200% of the federal poverty level.

The CHIP program is available to:

- Uninsured children (up to age 19) in families with income up to 206% of the federal poverty level.

Healthy Families

Healthy Families is a Medicaid program available to:

- Families with income up to 90% of the federal poverty level and a child younger than age 19.

Ohio Medicaid

2022 Monthly Financial Eligibility
Children, Families, and Adults

Family Size	Parents/Caretaker Relatives	Adults (age 19-64)	Children with Insurance	Pregnant Women	Children without Insurance
	90% FPL	**133% FPL**	**156% FPL**	**200% FPL**	**206% FPL**
1	$1,020	$1,507	$1,767	$2,265	$2,333
2	$1,374	$2,030	$2,381	$3,052	$3,144
3	$1,728	$2,553	$2,994	$3,839	$3,954
4	$2,082	$3,076	$3,608	$4,625	$4,764
5	$2,436	$3,599	$4,222	$5,412	$5,575
6	$2,790	$4,122	$4,835	$6,199	$6,385
7	$3,144	$4,646	$5,449	$6,985	$7,195
8	$3,498	$5,169	$6,062	$7,772	$8,005
9	$3,852	$5,962	$6,676	$8,559	$8,816
10	$4,206	$6,215	$7,290	$9,345	$9,626
11	$4,560	$6,738	$7,903	$10,132	$10,436
12	$4,914	$7,216	$8,517	$10,919	$11,246

Apply online: https://benefits.ohio.gov

Contact hotline: 1-800-324-8680

Christ Hospital Orthopedic Program

CENTER *of* EXCELLENCE

WHAT IS COVERED IN THE PROGRAM?

- The initial orthopedic consult, if surgery is indicated.
- Preadmission testing at a Christ Hospital Health Network facility.
- History & physical examination by a Christ Hospital provider. Please note: Patients traveling from out of town may use a practitioner at The Christ Hospital for their history & physical when in town if convenient. If you choose to have your history & physical by a provider other than a Christ Hospital provider it will not be covered under the program and normal insurance benefits will apply.
- Your Surgical Procedure and Hospital Stay
- Durable Medical Equipment ordered at discharge by your surgeon.
- Post-operative care (not including therapy) related to the surgery for 90 days following surgery if care is performed at a Christ Hospital facility and by a Christ Hospital provider.

HOW DO I GET STARTED?

To get started call 1-888-936-7246. An Optum/UHC Nurse will begin the process by gathering some information from you, then provide you next steps on entering the program. **You must contact an Optum/UHC nurse prior to scheduling any procedure to be eligible for the program.** You can also visit our website at www.TheChristHospital.com/clermont-county

HOW DO I CHOOSE A SURGEON?

A Christ Hospital Orthopedic Nurse Navigator is available to provide background and answer questions about the select surgeon panel for this program to assist you. The Nurse Navigator is also available to answer questions about the procedure, provide you with information on what to expect before and after surgery, how to best prepare for surgery, pre-surgery education classes, scheduling assistance and any other questions you may have concerning the program.

HOW DO I CONTACT THE CHRIST HOSPITAL NURSE NAVIGATOR?

The Nurse Navigator phone number is 513-557-4882 for joint replacement surgery or 513-557-4881 for spine procedures covered in the program. You can also email the Nurse Navigators at jointcare@thechristhospital.com. Finally, you can also visit the Centers of Excellence web page at www.thechristhospital.com/COE.

IN ADDITION TO THE NURSE NAVIGATORS, HOW DO I LEARN MORE ABOUT MY PROCEDURE PRIOR TO SURGERY?

Educational classes are offered on both joint replacement and spine procedures at The Joint & Spine Center and via web-ex. We encourage your participation in these classes and welcome you to bring a family member or care giver with you should you decide to attend. The Nurse Navigator can share dates and times of these classes with you to help you select a convenient time for you to attend.

ABOUT THE CHRIST HOSPITAL JOINT & SPINE CENTER

- The first of its kind in the region—providing comprehensive, evidence based joint and spine care, inpatient and outpatient orthopedic care, education and clinical outcomes research all in one facility.
- All private patient rooms with a comfortable space for family and visitors.
- Patient control of curtains, heating/cooling, lighting, television and bed—all with a push of a button.
- Modern amenities including phone and tablet charging stations at bedside.
- Stunning views of Downtown Cincinnati.
- Patient care and public areas with abundant natural light.
- Personalized dining service (Dining on Demand), similar to room service, for patients.

To view a virtual tour of the Joint & Spine Center, visit *www.tchvirtualtours.org/jsc-tour*.

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

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

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

Employee Assistance Program (EAP)

Counseling services (up to 5 visits per year) provided to Clermont County employees and their immediate family members through Tri-Health Services – paid by Clermont County. These services are 100% confidential; Clermont County receives no identifiable information. The EAP is staffed by trained professionals. Services include:

Personal & Mental Health	Conflict Resolution	Retirement Planning
Grief Counseling	Anger Management	Locating Dependent Care
Work Related Issues	Drug, Gambling, Alcohol Addictions	Personal and Group Help Available

To schedule a confidential appointment, call TriHealth at 513-891-1627. For urgent situations, call the TriHealth 24/7 line at 800-642-9794 or visit their website at https://www.trihealth.com/institutes-and-services/trihealth-corporate-health/concern-services.

Hearing Aid Benefit

Includes coverage for the cost of a hearing test with a licensed audiologist and for the cost of hearing aids. This benefit is for employees and family members. The benefit for the hearing aids is up to $5,000 and limited to one set of hearing aids every 3 years. You may use your UnitedHealthcare coverage card when visiting the audiologist and for payment of the hearing aids. The cost of hearing aids in excess of $5,000 every 3 years will be a member responsibility.

Genetic Testing

One of the recent innovations in the treatment of mental health conditions is a simple test that analyzes how your genes may affect medication outcomes. Common genetic tests analyze clinically important genetic variations in your DNA. Results can inform your doctor about how you may respond to certain medications commonly prescribed to treat depression, anxiety, ADHD and other psychiatric conditions.

This type of test must be ordered by your doctor or nurse practitioner. The test is often a cheek swab taken in your healthcare provider’s office or can be sent by your doctor to be taken in the convenience of your home.

Additional Medical Plan Programs for *those enrolled in the medical plan*

Real Appeal

Real Appeal® is a digital weight loss program customized to what works for you.

With Real Appeal, you learn simple steps to help you transform.

Enroll today at

enroll.realappeal.com

For the best experience, access Real Appeal from your own device.

Quit for Life No Cost Program

When you quit tobacco, good things start to happen. Your lungs begin to heal and you regain your sense of taste and smell. Best of all, your risk for heart disease, stroke and lung cancer may be dramatically reduced, which may lead to an average life expectancy that is 10 years longer than if you had kept smoking.[1]

Quit For Life® is a clinically proven program that offers a customized quit plan, 24/7 personal support and strategic tools to help you manage cravings.

DID YOU KNOW?

You pay
$0
because Quit For Life is a **$0-cost program** as part of your health plan benefits.

Act now to start enjoying better health for years to come.

quitnow.net

1-866-QUIT-4-LIFE, TTY **711**

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** / bughert@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.

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.clermontcountyohio.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	UnitedHealthcare Insurance Company	800-357-0978	www.myuhc.com
Prescription Coverage	MagellanRX	800-424-3312	www.magellanrx.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
Section 125	Chard, Snyder and Assoc., Inc. (TPA)	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	866-486-7721	www.starrobbins.com
Long Term Disability (LTD)	Trustmark	866-486-7721	www.starrobbins.com
Employee Assistance Program (EAP)	TriHealth	513-891-1627	www.trihealth.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.

Clermont County

Important Legal Notices

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage.
Please see page 7 for more details.

IMPORTANT NOTICE: This document is provided to help employers understand the compliance obligations for Health & Welfare benefit plans, but it may not take into account all the circumstances relevant to a particular plan or situation. It is not exhaustive and is not a substitute for legal advice.

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: Copay Plan: Ded. Single $2,000/ Family $4,000, Coinsurance: 80/20%. HDHP Plan: Single $3,200 / Family $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.

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.

Recipients of the notice are encouraged to read the entire notice. 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 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.

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/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.

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/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.
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 (if applicable), and we will mail a copy to you.

Other Instructions for Notice
- Effective Date of this Notice: January 1, 2024
- Yvonne Smith, Employee Benefits Coordinator, ysmith@clermontcountyohio.gov, Phone: 513-732-7981

If you are receiving this electronically, you are responsible for providing a copy of this notice to any Medicare Part D-eligible dependents who are covered under the group health plan.

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 United Healthcare Plans 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, your current Clermont County coverage will be affected.

In Network Benefits-Retail	Copay Plan	HDP Plan
Tier 1	$15 copay	10% coinsurance after deductible
Tier 2	$50 copay	10% coinsurance after deductible
Tier 3	$70 copay	10% coinsurance after deductible
Tier 4	25% coinsurance	10% coinsurance after deductible

If you do decide to join a Medicare drug plan and drop your current Clermont County coverage, be aware that you and your dependents will be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with 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:	01/01/2024
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

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, 2023. 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	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	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://kidshealth.ky.gov/Pages/index.aspx 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/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	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. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: 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**
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.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

CHIP Phone: 1-800-986-KIDS (5437)	
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	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
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, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 9-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact ______________________________.

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.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

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:
  - [x] All employees. Eligible employees are:

    Employees working 30+ hours per week

  - [ ] Some employees. Eligible employees are:

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

    Dependents of eligible employees

  - [ ] We do not offer coverage.

[x] 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 will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

• An employer – sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36 B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Clermont County Benefits Office

Yvonne Smith
Employee Benefits Coordinator
101 E. Main Street
Batavia, Ohio 45103
513-732-7981
ysmith@clermontcountyohio.gov

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.