Wood County Employee Health Benefits Plan

Health Benefits Guide

2026 Summary Plan Description • Employee Website: www.woodcountyohio.gov

Welcome to the Wood County Employee Health Benefits Plan

This Guide summarizes in general terms information contained in the Wood County Employee Health Benefits Plan Document. The Plan Document is available to view on the Employee Website.

Coverage is offered to eligible employees through an agreement between your Appointing Authority and the Wood County Commissioners, the Trustees/ Plan Sponsor of the Employee Health Benefits Plan (Plan). Every department has an Insurance Group Representative who submits your information to the Plan on behalf of your Appointing Authority.

The Plan's benefit period is the calendar year, (i.e., January - December).

Visit the Employee Website for the most up-to-date information on the Plan. If you do not have internet access, a copy of the Plan Document may be obtained from your Insurance Group Representative or by calling the Benefits Line at 419.354.1373.

Every Minute Counts!
Get Rewarded for Investing in You

Benefit eligible employees can earn a deductible credit toward the 2027 medical deductible along with reimbursements for eligible programs.

To earn up to a $100 credit, simply complete a wellness screening in 2026 and report your active minutes throughout 2026.

Refer to the wellness program information beginning on page 19.

2026 Rates

Premiums will increase for 2026 as outlined on page 6. Employees will see an increase of $5.52 per payroll deduction if electing all single coverage and $14.92 for family coverage. The premium increase reflects Plan costs and medical inflation.

Benefit Updates

Benefit enhancements for 2026 include the addition of:

- Chronic Condition Management Program
- Vaccination availability at pharmacies (eff. Sept. 23, 2025)
- Expanded nutrition counseling
- Contraceptives/birth control coverage
- Autism Spectrum Disorder therapies and outpatient behavioral health services
- Prescription Benefit Preservation Program

For more information on these services, see the Plan Document.

New medical and prescription ID cards will be distributed in late December. For your convenience, ID cards will also be available for download from the carriers' websites.

KEEP MORE MONEY IN YOUR POCKET

As a self-insured plan, all premiums collected through your payroll deductions, along with your employer's monthly contributions, are placed into one "pocket" of money known as the Employee Health Benefits Trust.

The Trustees encourage you to be wise consumers when utilizing the benefits provided under the Plan to help lower costs and maintain a viable plan for the future.

You can help reduce the amount needed to fund the Plan by:

- Utilizing network providers for maximum savings and protection from balanced billing.
- Transferring your medical primary care provider to the Community Health Center for access to $5 prescriptions through the Prescription Savings Program. If not utilizing this program, maximize your savings by price shopping for prescriptions. Pharmacies have different negotiated rates which may be costing you more out of your pocket.
- Shopping around for discounts for eye exams, glasses and contacts.
- Obtaining precertification for services to avoid claim denial or penalties.
- Participating in the Site of Care Program for infusions and injections, when needed.

The Wood County Employee Health Benefits Plan is a non-federal, governmental, self-insured, non-ERISA plan. The Plan is a "grandfathered health plan" under section 1251 of the Affordable Care Act (ACA).

As permitted by the ACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. While some provisions of the ACA apply to all plans, grandfathered plans may keep their current plan design and do not have to provide certain free benefits including preventative care. The ACA only applies to health and prescription coverage.

The Plan also provides minimum essential coverage and meets the minimum value and affordability standards under the ACA for the benefits it provides.

The Plan reserves the right to develop and/or modify eligibility rules.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered status can be directed to the Commissioners' Office at 419.354.9100. You may also contact the U.S. Department of Health and Human Services at www.hhs.gov.

Employees may request a copy of IRS Form 1095-C (Employer-Sponsored Health Insurance Offer and Coverage) by contacting the Benefits Line at 419.354.1373 or emailing benefits@woodcountyohio.gov. Forms will be provided no later than January 31 or 30 days after the date of request.

Eligibility Guide

In addition to eligibility information contained in this Summary Plan Description, an Eligibility Guide has been developed to assist you in determining eligibility for yourself and your dependents. The Eligibility Guide is available on the Employee Website.

If determined benefit-eligible, you are required to elect or waive coverage within 30 days of becoming eligible. Provided all required information is received, coverage will commence on the effective date as noted in the Eligibility Guide.

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of enrollment in 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 dependent's other coverage). However, you must request enrollment within 30 days after your 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 if eligible. Under this special enrollment right, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you or your children are eligible for premium assistance under Medicaid or the Children's Health Insurance Program (CHIP), as well as eligible under this Plan, the Plan will allow you to enroll within 60 days of either being determined eligible for premium assistance or after Medicaid or CHIP coverage terminates.

Open Election Period: November 15 through December 15

Benefit eligible employees are automatically re-enrolled in their existing coverage for the following calendar year.

Each year during the annual Open Election period, you have the opportunity to enroll in, or make changes to, your benefits without a Special Enrollment Right.

To request a change for the 2026 plan year, you must submit a completed Universal Application and any required documents and certification forms to your Insurance Group Representative by December 15, 2025. Changes become effective January 1, 2026.

Omnibus Budget Reconciliation Act of 1986 (OBRA)

OBRA law requires you to notify the Plan when a Plan participant becomes disabled or reaches age 65. Plan participants must elect primary coverage under this Plan or Medicare. Wood County provides employees/dependents over the age of 65, or disabled, the same group health plan coverage provided for employees/dependents under age 65. You must report the election on the Primary Coverage Selection Form (OBRA) which is available on the Employee Website. The Plan is subject to Medicare regulations.

INSURANCE BENEFIT ELIGIBILITY

Eligibility is based on your Hours of Service as required by the ACA and its shared responsibility provision. Hours of Service include hours for which you are paid for the performance of duties or entitled to payment for paid leave such as vacation, holiday, sick leave, etc.

The Insurance Group Representative for your hiring department reports your information to the Plan Sponsor by submitting ACA Compliance Reports at the time of your hire or change in hours/status. Following receipt of these reports, the Plan communicates benefit eligibility to you through your Insurance Group Representative. Eligibility continues provided eligibility rules are met throughout the calendar year.

Benefit Eligibility	Offer of Coverage
Full Time (ACA) (defined as 30 Hours of Service or more per week, or 130 Hours of Service per month excluding seasonal employees)	Coverage is offered upon completion of a 30-day waiting period in full time status and is effective the first day of the next month. Employee must maintain an average of 30 Hours of Service a week per calendar month and will be measured under the Monthly Method until the Standard Look-back Method can be applied. ACA benefit eligible employees are offered Medical/Prescription, Vision, Dental and mandatory Life Insurance. Eligible employees along with their legal spouses and dependents, may be covered as long as they meet the Plan's eligibility rules. At any time, the Plan may require proof of eligibility.
Part Time, Seasonal, or Variable Hour (Not ACA full time at the time of hire)	Coverage offer is delayed utilizing the Initial Look-back Method to determine benefit eligibility. If benefit eligible, coverage is offered upon completion of a 30-day waiting period and is effective the first day of the next month through the Initial Stability Period. Employees may participate in certain wellness programs offered under the Plan.

Enrollment

During the 30-day waiting period (enrollment period), you must elect or waive coverage and complete the mandatory Wellness Screening. If enrolling in more than one insurance plan (e.g., secondary coverage), it is your responsibility to ensure proper enrollment in this Plan as the IRS and other federal regulations may limit enrollment/coordination between certain plans. All reported names must match the individual's social security card.

If you fail to complete and submit the application and any required forms or do not complete the Wellness Screening within the enrollment period, you will not be eligible to enroll in the Plan until the next Open Enrollment period, unless you experience a Special Enrollment Event or a Status Change Event.

Ongoing Eligibility

If you were hired after October 6, 2024, your Hours of Service are measured using the **Monthly Method** as listed on page 4. Failure to meet the eligibility requirement during a month will result in ineligibility for benefits and retroactive termination of benefits for that month if enrolled. Following loss of eligibility, enrollment is reinstated the first day of the month in which you meet the eligibility requirement. You transition to the Look-Back Method following completion of a full Standard Measurement Period which may take up to 24 months.

If you were hired on or before October 6, 2024, the Plan will determine your 2026 eligibility using the **Look-Back Method** Standard Measurement Period from October 6, 2024, to October 4, 2025. If you meet 1,560 Hours of Service during that period you will be benefit-eligible for the Standard Stability Period (2026 calendar year) as long as you remain an active employee with Hours of Service during the month of coverage or are on leave protected by FMLA. Generally, coverage terminates at the end of the calendar month in which you separate service or change employment status, provided your portion of the premium is received.

If you are non-full time or a Seasonal employee hired after October 6, 2024, your Hours of Service are reviewed using the **Look-Back Method** Initial Measurement Period which runs 26 full pay periods following your date of hire. You will be notified if you measure benefit-eligible following completion of your Initial Measurement Period.

Special rules apply if you are rehired, return from an unpaid leave, or change employment status (e.g., returning with a non-retirement break in service of less than 13 weeks will be considered as continuing your employment).

Employee Eligibility Certification Process

Questions regarding your eligibility may be directed to the Benefits Line at 419.354.1373 or email benefits@woodcountyohio.gov.

The Plan utilizes two Measurement Methods to determine benefit eligibility under the Affordable Care Act: Monthly and Look-Back.

Monthly Method: used to count Hours of Service for new full time or non-seasonal employees who are enrolled in the Plan and have not completed a full Standard Measurement Period under the Look-Back Method. (Refer to the chart below for Standard Measurement Period dates.)

- Requires an average of 30 Hours of Service per week (130 per month) or more per calendar month until the Standard Stability Period can be applied.
- Eligibility may change month to month - If not eligible for month, coverage will terminate retroactive to the last day of the prior month.
- Employees may be measured monthly for up to 24 months depending on date of employment.

Look-Back Method: used to count Hours of Service for new hires who are Part Time, Seasonal, or Variable Hour, as well as on-going employees. Employees with 1,560 Hours of Service or more during the Measurement Period are considered benefit-eligible. There are two types of Look-back Methods: Initial and Standard.

Initial Look-Back Method: used for new hires who are part time, seasonal or variable hour who are not benefit eligible at hire.

Standard Look-Back Method: applied to all employees on an annual basis provided they are employed for the full Standard Measurement Period.

Both methods are divided into three parts as defined below:

A **Measurement Period** for counting hours of service.

- Initial: First full 26 consecutive pay periods after date of hire.
- Standard: Predetermined by the Plan as listed below.

An **Administrative Period** to determine and communicate eligibility. Benefit eligible employees must elect or waive coverage during this period.

- Initial: Up to 30 days plus the remainder of the month following the completion of the Initial Measurement Period.
- Standard: 90-day period following the Standard Measurement Period.

A **Stability Period** in which an employee is considered benefit eligible or not benefit eligible.

- Initial: First day of the month following the Initial Administrative Period through the next 12 months
- Standard: January 1 to December 31 following the Standard Measurement Period.

STANDARD LOOK-BACK METHOD FOR 2027 ELIGIBILITY

Measurement Period	Administrative Period	Stability Period
Oct. 5, 2025 to Oct. 3, 2026 Employee must obtain 1,560 Hours of Service to be benefit eligible for 2027.	Oct. 4, 2026 to Dec. 31, 2026 Plan reviews Hours of Service during Measurement Period to determine eligibility and notifies employees of gain or loss of eligibility.	Jan. 1, 2027 - Dec. 31, 2027 Coverage offered to benefit eligible employees provided employee portion of premium received and at least one Hour of Service is rendered during each month.

2028 Standard Measurement Period for Employee Eligibility

Oct. 4, 2026 - Oct. 2, 2027

Dependent Eligibility Certification Process

In addition to initial certification at the time of enrollment, the Plan requires annual certification to determine spousal and overage dependent child eligibility. If enrolling after August, certification for the current and upcoming plan year will be required. Annual certification occurs from September 1 to 30. The Plan reserves the right to recover payments made during a period of time in which your Dependent failed to meet the requirements of an eligible Dependent. See the Plan Document for complete eligibility rules.

Spousal Eligibility: Medical & Prescription, Vision and Dental

Based on your spouse's annual adjusted gross income, as determined through the certification process, your spouse may qualify for primary coverage with or without a spousal premium.

- **Income Less than $33,500**
  Spouse may be primary under Family Coverage, a spousal premium will not apply.
- **Income $33,500 to $63,200**
  Spouse may be primary, the spousal premium will apply in addition to the Family Coverage rates listed on page 6.
- **Income Greater than $63,200**
  Spouse may be secondary under Family Coverage. Primary coverage is not available.

Your spouse may be eligible for secondary coverage provided valid primary insurance information is submitted.

Spouses seeking coverage under any benefit **must** complete a wellness screening during the 30-day enrollment period.

Coordination of Benefits:
Know the Rules When Enrolled in Multiple Plans

- The plan that covers the individual as an employee will pay primary and the plan that covers the individual as a dependent will be the secondary payor.
- Primary coverage must be documented to enroll as secondary.
- If both parents cover children, the birthday rule applies to determine who carries primary coverage. The parent's birthday that comes first in calendar year is primary.
- Federal rules may limit or restrict enrollment in this plan.
- See the Plan Document for additional information, including information on divorced parents.

Dependent Child Eligibility: Medical and Prescription

Your biological, adopted (includes placed for adoption), or stepchild is eligible to enroll on your family coverage from birth to the end of the month in which he/she attains age 26.

Dependent Child Eligibility: Vision and Dental

Your child is eligible for coverage on your family coverage from birth until the end of the calendar year in which he/she reaches the limiting age of 19 or until the end of the calendar year in which he/she reaches the limiting age of 23 if he/she is a full time student at an accredited school. A child shall include:

- Natural, legally adopted children or children placed with a covered employee in anticipation of adoption who are:
  - Unmarried; and
  - Not employed on a regular full time basis; and
  - Not covered under the Plan as an employee; and
  - Dependent on you or your Spouse for more than 50% of his/her financial support; and
  - Your dependent for tax exemption purposes under Section 152 of the Internal Revenue Code
- Stepchild or child under your or your spouse's legal guardianship who meets all the requirements listed above and:
  - Lives in your home for more than half of each calendar year in a regular parent-child relationship (a regular parent-child relationship does not exist if the Child's parent, other than your Spouse, also resides within the household.); and
  - Is wholly dependent on you for financial support.

Full time student coverage continues only between semesters/quarters if the student is enrolled as a full time student in the next regular semester/quarter.

Any child for whom you are required to provide health coverage due to a Qualified Medical Child Support Order (QMCSO), including any appropriately completed National Medical Support Notice (NMSN), shall be considered as having a right to Dependent coverage under this Plan.

Coverage for a disabled child over the limiting age may be available provided you submit the required written documentation within 60 days after you first request enrollment of your dependent or within 60 days following the dependent's attainment of the limiting age, whichever is later. See the Plan Document for additional information.

The following are excluded as Dependents:

- Other individuals living in your home, but who are not eligible as defined;
- Your legally separated or divorced former Spouse (even when a court order has been issued requiring you to provide health insurance for the divorced Spouse);
- Any person who is on active duty in any military service of any country; or
- Any person who is covered under the Plan as an employee.

How Premiums Are Collected

Monthly premiums are collected through employer and employee contributions as outlined below. The employer pays 85% of the total premium. The remaining 15% of the total premium is paid by the employee and is automatically collected through payroll deductions which are split between the first and second pay dates of each month. The premium may be collected on a pre-taxed basis under the Section 125 Premium Only Plan.

2026 MONTHLY PREMIUMS

Single Coverage	Total Rate	Employer	Employee	COBRA
Medical and Prescription	$873.00	$742.06	$130.94	$890.46
Vision	$9.18	$7.80	$1.38	$9.37
Dental	$34.22	$29.10	$5.12	$34.91
Life*	$8.54	$8.54	$0	N/A
Total	$924.94	$787.50	$137.44	

Family Coverage (2 or more)	Total Rate	Employer	Employee	COBRA
Medical and Prescription	$2,357.10	$2,003.54	$353.56	$2,404.25
Vision	$24.80	$21.08	$3.72	$25.30
Dental	$92.42	$78.56	$13.86	$94.27
Life* (Employee Only)	$8.54	$8.54	$0	N/A
Total	$2,482.86	$2,111.72	$371.14	

* Employer funds 100% of the premium.

Spousal Premium Rates

Refer to the Spousal Eligibility section on page 5 to see if an additional premium applies for spousal coverage. The Spousal Premium is in addition to the employee's portion of the Family Coverage rate listed above and is funded 100% by the employee. The premium is collected through payroll deduction and can be collected on a pre-taxed basis.

Medical and Prescription	$873.00
Vision	$9.18
Dental	$34.22

Insufficient Wages for Payroll Deduction

During a month in which you are enrolled in coverage and your wages are insufficient to collect your portion of the premium for one or both of the scheduled payroll deductions, the payroll deduction will stop. You will be required to self-pay the full employee portion of the monthly premium by the last day of the month prior to the month of coverage. You must give five working days advance notice if you choose to continue coverage.

If you fail to provide proper payment, coverage will terminate retroactive to the first of the month for which payment was not received. If you are in a Stability Period and lose coverage due to a failure to pay the premium, you are not permitted to re-enroll in the Plan for the remainder of the Stability Period unless a Qualifying Event is experienced, and retroactive premiums are paid upon re-enrollment.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

Plan participants no longer eligible for coverage may be eligible to continue coverage at their own expense under Public Law 99-272 Title X, commonly referred to as COBRA. Participants are notified of their COBRA rights upon enrollment in the health benefits program. When coverage terminates, employees must complete a COBRA personnel action report form to determine COBRA eligibility. Written communication regarding COBRA offerings are mailed to the affected employee and/or spouse and dependents following termination of benefits.

Prescription Savings Program

Partnering with the

Wood County Health Department
Community Health Center

Save up to $520 annually on prescriptions by partnering your primary medical care with the Wood County Community Health Center and the Prescription Savings Program!

If you are on maintenance medications, moving just one Tier 2 medication from the retail pharmacy to the Prescription Savings Program at the Community Health Center can lower your prescription cost by up to **$520** annually.

Even if you don't need the Prescription Savings Program now, consider establishing your primary care at the Community Health Center to have future access to the pharmacy.

* Some restrictions apply.

Savings Example: Eliquis 4 mg tablet

Location	Copay
Retail Pharmacy 12 - 30-day fills	$45 per month $540 Annually
Mail Order	Not available: Drug > $1,000 limited to retail pharmacy or RX Savings Program
RX Savings Program **4 - 90-day fills***	**$5** **$20 Annually**

Making the switch to Community Health Center is easy!

- Call 419.354.9049 to schedule an appointment.
- Sign-off on a *Release of Information* to transfer information from current primary care provider to the Community Health Center
- You can keep your specialist!

Community Health Center Hours

Monday: 8:30 a.m. - 6 p.m.
Tuesday, Wednesday, Thursday: 8:30 a.m. - 4:30 p.m.
Friday: 8:30 a.m. - 2 p.m.
Closed on weekends and holidays

Pharmacy Hours

Monday: 9 a.m. to 6:30 p.m.
Tuesday, Wednesday, Thursday: 9 a.m. to 5 p.m.
Friday: 8:30 a.m. to 2 p.m.
The pharmacy is closed for lunch between 1 p.m. and 2 p.m.

As a federally qualified health center, the Community Health Center provides comprehensive primary and preventive care. The Center is located at the Wood County Health Department at 1840 East Gypsy Lane Road.

Unique benefits realized by establishing primary care at the Wood County Community Health Center include the following:

- Family Practice (Health Care services for your entire family)
- Pharmacy services for Center patients
- Women's Health Care
- Social Work Services
- Counseling/Behavioral Health Specialist
- Assistance with enrolling in Marketplace insurance
- Financial Assistance/sliding fee scale for those who qualify
- Non-Wood County residents welcome

When you need immediate care, knowing your options can save you time and money.

Urgent Care vs. Emergency Care (ER)

One of the more difficult health care choices you may be faced with is where to go when you need medical attention for a sudden injury or illness.

Often times, we automatically think we need to go to the emergency room when we need urgent care - assuming that it is our only option for after-hours medical attention. We may also think that since it is open 24 hours a day, we will receive prompt care in an emergency room, but often, the opposite is true.

If your injury or illness is minor, you may find yourself waiting for a long time while others with more serious problems are evaluated and treated. Also, a visit to the ER for non-emergency care can cost three to four times more than a visit to an urgent care center for the same ailment and if it is not medically necessary for an ER setting, the bill can become your responsibility.

Always seek emergency care if you believe you are experiencing a medical emergency that requires immediate attention to avoid severe injury, serious impairment, disability, or death.

If you cannot get into your doctor and have an urgent need, consider Falcon Health Center. The physicians, nurse practitioners, nurses and medical assistants at the Center provide treatment for minor ailments and injuries that need prompt attention, but don't require a visit to the emergency room. Falcon Health bills at the doctor office rate which is lower than an urgent care facility.

Located at 838 East Wooster Street in Bowling Green, Falcon Health welcomes members of the Wood County community, who are six months and older. Walk-in patients will be seen on a first come, first serve basis. Co-pays are due at the time of the visit.

Falcon Health Center Hours*:

FALCON HEALTH CENTER

Facility, Radiology & Lab Hours:
Monday - Friday: 8 a.m. - 8 p.m.
Saturday & Sunday: 9 a.m. - 5 p.m.
Closed on holidays
Pharmacy Hours: Monday - Friday: 8 a.m. – 8 p.m.
(drive-thru window available)
Summer hours may vary.

For more information, or to make an appointment, call 419.372.2271.

* Hours subject to change based on facility needs.

Privacy Practices: Notification of Availability

A copy of the Notice of Privacy Practices is available to all Plan participants under the insurance link on the Employee Website, through your Insurance Group Representative, or from the Commissioners' Office.

The Notice of Privacy Practices describes how protected health information may be used or disclosed by your group health plan to carry out payment, health care operations, and for other purposes that are permitted or required by law.

The Notice also sets out our legal obligations concerning your protected health information, and describes your rights to access and control your protected health information (PHI). The Plan does not share PHI or genetic information with any appointing authority or use the information for employment related purposes.

If a participant wishes to permit his or her spouse or other designee to discuss coverage with the Plan or Plan Administrators, the participant must sign-off permitting the designee access to the protected health information on an annual basis. Under HIPAA regulations, a separate sign-off will be required for the Plan and each Plan Administrator.

Questions should be directed to:
Janese Diem, Privacy Officer, Wood County Commissioners' Office
One Courthouse Square, Bowling Green, Ohio 43402
Benefits Line: 419.354.1373
Confidential Fax: 419.353.7429
Email: benefits@woodcountyohio.gov

30-Day Reporting Period Applies to Report Changes to Coverage

To report a change to your coverage, you must submit a completed Universal Insurance Application and any required forms to your group representative within 30 days of the event.

If you miss the 30-day reporting period, you may not be able to make the change until the next Open Election period.

The following are examples of events that require notification to the Plan in order to update your insurance coverage.

- Address change
- Marriage
- Name change
- Birth/Adoption
- Divorce/Legal Separation
- Death of a covered family member
- Coordination of benefits changes (new or changes in other coverage)
- Change of life insurance beneficiary
- Military leave
- Employment status changes: Part time to full time, full time to part time status, or other change in hours
- Medicare eligibility through age or disability
- Expiration of COBRA
- Spouses and/or dependents obtaining or losing other insurance coverage/ employment
- Dependents over the age of 19 enrolling or leaving college (vision and dental coverage only)
- Employment termination
- Any other changes that affect insurance coverage

Claim Questions? Contact Customer Service

Questions regarding an Explanation of Benefits (EOB) or other claim issue can be directed to the Claims Processor's customer service department as noted on the back page of this document.

Prior to calling customer service be prepared with the following information:

- Subscriber's name and social security number
- Patient's name
- Provider's name and address
- Date(s) of service
- Nature of the issue
- Copy of Explanation of Benefits if received.

When calling be sure to always note:

- The customer service representative's name
- The date and time of the call
- A brief summary of the explanation provided
- Next steps to resolve the matter
- Who will do the next step

Follow-up is extremely important and may also require you to make a few phone calls to your provider to request they resubmit a claim or provide the missing information to process the claim. Be sure to call customer service back to verify receipt of any missing information.

Most of all, be patient and remember to focus on the facts. Remember it takes a few weeks to process the paperwork.

If the matter is not resolved within a reasonable time frame, contact your Insurance Group Representative for assistance.

Should you wish to appeal a claim, be mindful of the appeal timelines provided on the Explanation of Benefits and in the Plan Document.

MEDICAL COVERAGE

Total Monthly Cost
(Medical/Prescription Coverage)

Single	$873.00
Family	$2,357.10

Employee Payroll Deduction
(1st & 2nd pay of month)

Single	$65.47
Family	$176.78
Spousal Premium in addition to family premium	$436.50

Copay
(Not applied to Deductible/Coinsurance)
Professional (Office Visit)
$15 per visit
Technical (Emergency Room)
$45 per visit

Annual Deductible

In-Network	Out-Of-Network
$150 Single	$300 Single
$450 Family	$900 Family

Out-of-Network deductible applies to In-Network deductible.

Annual Coinsurance

In-Network	Out-Of-Network
80% Plan	60% Plan
20% Subscriber	40% Subscriber

Maximum Annual Coinsurance Expenses

In-Network	Out-Of-Network
$ 250 Single	$ 500 Single
$ 750 Family	$1,500 Family

Maximum Out-of-Pocket
(Total Deductible + Coinsurance, not including copay)

In-Network	Out-of-Network
$400 Single	$800 Single
$1,200 Family	$2,400 Family

Maximum Annual Benefit
Essential services - No limit

Save Money by Choosing In-Network Participating Providers

The Wood County Employee Health Benefits Plan contracts with FrontPath Health Coalition for access to their network of providers. By choosing in-network providers, plan participants are protected from balance billing.

FrontPath's website maintains a list of in-network providers. Visit www.frontpathcoalition.com.

Claim Submission Reminder

When seeking services, remind your provider to forward all claims to FrontPath using the address on the back of your insurance card. Claims sent directly to Meritain will be denied causing delays in claim processing.

Eligible Medical Expenses

Services listed in the Medical Schedule of Benefits listed on Page 11 will be considered eligible only if they are medically necessary due to illness or injury and are not experimental and/or investigational unless otherwise specified in the Plan Document. Limitations may apply.

Predetermination of Benefits

If you are unsure if a service will be covered under the Plan, you may request a Predetermination of Benefits through Meritain's customer service. This process may take 15 to 30 business days to complete.

Predetermination is separate from any precertification requirements.

Precertification Requirements

Certain medical and prescription services require precertification. These services are listed on the back of your medical ID card along with the required timeframe for completing the precertification. Precertification requirements are also fully described in the Plan Document.

Medical Precertification: As a reminder, precertification is ultimately the responsibility of the member. Your provider should precertify your treatment for you; however, Out-of-Network Providers do not have a contractual obligation to precertify services on your behalf.

Prior to receiving services you should verify that your provider has obtained precertification by either confirming with the provider or contacting the Medical Management Program Administrator listed on your ID card.

Prescription Precertification: Your provider must complete the prescription Medical Necessity Review form for prescriptions over $1,000 and outpatient infusions/injections prior to receiving services.

Medical Schedule of Benefits

The following is a list of eligible medical expenses under the Plan. Refer to the Plan Document for a full description of these benefits. The Plan reserves the right to direct/coordinate care.

Pre-Admission Testing and Second Surgical Opinion by a participating provider (voluntary/optional) are covered at 100% and are not subject to the deductible, coinsurance, and copay features.

The following services must be medically necessary due to illness or injury and are subject to deductible, coinsurance and copays. * Indicates precertification required.

- Allergy Testing, Serums & Injections
- Ambulance Services (note that some land ambulance services do not contract with networks)
- Anesthetics
- Autism Spectrum Disorder* - Speech & Language or Occupational Therapy**; Mental or Behavioral Health Outpatient service (**precertification required after 15th visit - 30 visit limit per Benefit Period)
- Blood and Blood Derivatives
- Cardiac Rehabilitation (Phase 1 and Phase 2)
- Chemotherapy*
- Chiropractic Care/Spinal Manipulation - 12 visits per benefit period
- Contraceptives
- Diagnostic Testing, X-ray, and Lab Services (Outpatient)
- Dialysis*
- Durable Medical Equipment
- Emergency Services/ER (within 72 hours of onset of symptoms)
- Facility Services - Inpatient*(semi-private room), Outpatient, Ambulatory Surgical Center, Hospital, Extended Care/Skilled Nursing, Rehabilitation*, Urgent Care Center, Hospice*
- Hearing Aids - $3,000 max benefit every four calendar years
- Home Health Care - 120 visits per benefit period
- Infusion* - Plan reserves the right to direct site of care
- Maternity Services* - Covered Medical Expenses payable for any hospital stay in connection with childbirth for the mother or newborn child will not be restricted to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the mother's (or newborn's) attending provider may, after consulting with the mother, discharge the mother or her newborn earlier than 48 hours (or 96 hours if applicable). Precertification required for extended stay.
- Medical and Surgical Supplies - Compression hose - 3 pair max per benefit period
- Morbid Obesity - $15,000 lifetime maximum benefit
- Nutritional Counseling/Education - 4 sessions per benefit period
- Orthotics - to limit or stop the motion of a weak or diseased body part
- Physician's Services - Inpatient*, Outpatient, Office Visit, Physician Office Surgery, Retail Clinics/Urgent Care, Telemedicine (6 visit max per benefit period)
- Podiatry Services
- Private Duty Nursing
- Prosthetics - First breast prostheses and surgical brassiere - 1 per lifetime Breast Reconstruction/ Prostheses due to Mastectomy — Coverage provided for a medically necessary mastectomy and election of breast reconstruction after the mastectomy for: reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce symmetrical appearance, and coverage for prosthesis and treatment of physical complications of all stages of mastectomies, including lymphedemas.
  Wig/Artificial Hair Piece - 3 per lifetime following chemotherapy or radiation therapy ($500 limit each);
  Cochlear Implant (see Plan Document for lifetime limit);
  First lens(es) due to cataract surgery/aphakic patients per lifetime;
- Radiation Therapy*
- Routine Care - Well Child Care (through age 18), Immunizations, Labs & X-rays
  1 each per benefit period - Routine Physical (18 & over, mammogram, gynecological exam, pap test, prostate exam and/or PSA)
  Routine colonoscopy limited to age 45 and over once every 10 years; $500 benefit period limit if receiving second routine colonoscopy within 10-year period
- Sleep Disorders
- Temporomandibular Joint Dysfunction (TMJ) documented organic disease/physical trauma
- Therapy - Occupational/Physical*: 30 visits of combined OT/PT per benefit period (precertification required after 15th visit); Respiratory/Pulmonary; Speech; Vision: diagnosis of Strabismus only - 1 course of treatment per lifetime, up to 32 visits
- Transplants* - The Plan reserves the right to direct payment for transplant services to transplant Centers of Excellence at the Plan's discretion.

Contact FrontPath to see if your provider is in-network.

www.frontpathcoalition.com
419.891.5206
members@frontpathcoalition.com

FrontPath's website also includes a Cost and Quality Portal where members can compare cost and quality for specific procedures based on providers in the network.

For the password to the site, contact your insurance group representative or the Commissioners' Office.

In-Network Providers vs. Out-Of-Network Providers: What Does it Mean?

A provider is a person or facility that provides healthcare services. When a provider is in-network with FrontPath it means there is a contractual agreement in place that determines the rate paid to that provider for the services rendered. Providers that are out-of-network do not have a contract in place to determine what rate will be paid for the services rendered.

Why Does Receiving Care at In-Network Providers Matter?

Seeing an in-network provider for medical services significantly reduces your medical expenses. The contractual agreement in place for in-network providers means that providers cannot charge you more than the negotiated rate for a service. Any costs you incur with an in-network provider (copays or coinsurance) are applied to your deductible and out-of-pocket maximum. Services received at Out-of-Network providers are not subject to a negotiated rate and costs incurred are not applied to your deductible or out-of-pocket maximum.

Balance Billing: What Do I Need to Know?

Balance billing occurs when out-of-network providers bill a patient directly for the difference between the billed Amount (amount the provider charges) and the Allowed Amount (amount your health plan plays plus your copay/coinsurance). Remember, providers who are out-of-network are not contractually obligated to accept reimbursement that is less than the amount they billed.

What is My Role?

Before receiving services, you should always confirm the provider is in-network by searching the online provider directory or contacting Frontpath's customer service. Also, a new trend in healthcare is for providers, particularly larger care facilities, to offer pre-pay discounts if you pay at the time of service.

It is not recommended that you pay for services before the claim has been fully adjudicated by our plan administrator as it could result in you paying more than required by the plan.

Chronic Condition Management through Teladoc Health

If you have pre-diabetes, diabetes, or hypertension you may be eligible to enroll in the Chronic Condition Management program through Teladoc Health.

With Chronic Condition Management, you have access to support and tools for managing your health conditions including lifestyle behavior change tools, expert health coaching, personalized plans for reaching goals and more. For additional information or to see if you qualify, visit www.TeladocHealth.com/Smile or call 1.800.TELADOC.

Note: The Teladoc visits under the Chronic Condition Management program will not apply to the six telemedicine visit limit under the medical benefit.

Who do I contact with questions about my medical coverage?	
Inquiring About:	**Who To Contact:**
Covered Benefits/Predetermination of Benefits	Meritain Health 1.800.925.2272
Deductible/Out-of-Pocket Maximums	Meritain Health 1.800.925.2272
Eligibility/Adding a Dependent or other changes	Commissioners' Office Benefits Line 419.354.1373
Precertification for Required Services	Meritain's Medical Manager 1.800.242.1199
Finding an In-Network Provider	FrontPath Health Coalition 419.891.5206
Claim Payment/Denial	Meritain Health 1.800.925.2272
Explanation of Benefits (EOB)	Meritain Health 1.800.925.2272
New ID cards	Meritain Health 1.800.925.2272

Meritain.com

Meritain is your contact for benefit questions and claim status. Using the Meritain Health member website you have 24-hour access to a number of tools and resources that can help you manage your medical benefits. Below are a few things you can do on meritain.com:

- Verify eligibility and benefits coverage
- Find the status of claims
- Access your ID card (view or print)
- View your Explanation of Benefits (EOB) documents
- Request Letter of Coverage (LOC)

Meritain Health® an aetna® company

Access is easy as 1-2-3!

Step 1: Open your web browser and go to www.meritain.com.

Step 2: To register your account, click Register and then click on the Member tab.
Note that your spouse and adult dependents will need to create their own accounts.

Step 3: Fill in your

- Group ID (located on your ID card)
- Member ID (also on your ID card) Enter the number with no spaces or dashes
- Date of Birth
- Name (as it appears on your ID card)
- Zip Code

You will be prompted to enter an email address, create a user name and password, and select a security question. Review the terms and conditions, click I agree to the terms and conditions and Next, or click Cancel.

The next time your log in, just use the same user name and password from Step 3.

PRESCRIPTION COVERAGE

The Wood County Employee Health Benefits Plan has adopted a Prescription Savings Program along with a Prescription Formulary.

PRESCRIPTION SAVINGS PROGRAM

The Prescription Savings Program combines quality medical care for ongoing, routine treatment with a low copay for prescription medications: up to a 90-day supply* for $5.

The Program is available to primary Plan members and does not coordinate benefits with other insurance coverage.

To utilize the Prescription Savings Program, the member must transfer primary care services to the Wood County Community Health Center. This grants members full access to the Center's on-site, full service pharmacy.

Members can continue to seek treatment from their specialist who may prescribe medication. The Center's pharmacist can provide information regarding the transition process.

To ensure the effectiveness of a medication, any prescription for a new medication will be limited to a 30-day fill. After that, a 90-day fill will be available with the exception of any prescription over $1,000. Those are limited to a 30-day fill. Note that not all medications are available through this program*.

Call the Benefits Line at 419.354.1373 with questions regarding the program or email benefits@woodcountyohio.gov.

* Some restrictions apply

Medicare Part D (Prescription Coverage)

Wood County has determined that the prescription drug coverage provided under the Employee Health Benefits Plan is, on average for all Plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is considered 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.

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two month Special Enrollment Period (SEP) to join a Medicare drug plan. For more information about Medicare Prescription Drug Coverage visit www.medicare.gov or 1.800.Medicare or refer to the Plan Document.

PRESCRIPTION FORMULARY

A prescription formulary is utilized for members seeking prescriptions outside of the Prescription Savings Program. Participants are responsible for their copay based on the drug tier and the Plan pays the balance. The formulary is integrated into the MedBen Rx member prescription portal.

The formulary identifies those medications most frequently prescribed and places them within tiers to create steerage to effective, lower net ingredient cost drugs. While the drugs in the list can be alternatives for one another, your specific dosage requirements must be determined by your doctor. Note that not all medications are covered under the formulary.

Updates to the formulary are made throughout the year based on market trends resulting in tier and/or coverage changes.

While a drug may be listed in the formulary, the drug may fall under the Plan's Excluded and Limited Services.

Generic drugs are required when available, or an added fee is imposed, unless specific instructions from the doctor are given (i.e., DAW - Dispense as written). Approved Over-the-Counter medications listed in the formulary require a valid prescription.

PRESCRIPTION COPAYS

Prescription Formulary Tier	Prescription Savings Program Copay 90-day supply*	Retail Pharmacy Copay 34-day supply maximum	Mail Order Copay 90-day supply maximum
Tier 1, select OTC with prescription, and vaccinations	**$5**	$5	$10
Tier 2	**$5**	$20 plus 20% of Total Claim Charge (TCC) $45 Maximum	$40 plus 20% of TCC $90 Maximum
Tier 3	**$5**	$20 plus 20% of TCC $85 Maximum	$40 plus 20% of TCC $170 Maximum

* Some restrictions apply Total claim Charge (TCC) = Drug Ingredient Cost plus Dispensing Fee

Select Over-The-Counter

The following Over-the-Counter (OTC) drugs are available under the Plan with a valid prescription.

Gastrointestinal - Esomeprazole OTC, omeprazole OTC, lansoprazole OTC, famotidine OTC, omeprazole w sodium bicarbonate capsules OTC

Sinus/Allergy - cetirizine OTC, cetirizine liquid OTC, loratadine, OTC, loratadine syrup, fluticasone nasal spray OTC, triamcinolone nasal spray OTC

Cold Sores - Abreva Cream

Eye Allergy - ketotifen

Excluded and Limited Services

Subscribers requesting the Plan to pay for drugs not covered may request an exception for coverage through the Medical Necessity Review process. Prior to purchase, the prescribing physician and employee shall complete a Medical Necessity Review form and submit it to the Plan for consideration. Forms are available from your Group Representative or on-line. Insufficient or incomplete information may result in a delay or denial of the claim.

If approved by the Medical Manager, the Plan will notify the Subscriber of the effective dates of coverage and any other limitations. In some cases, coverage may be limited to a 30-day supply. The Plan reserves the right to direct site of care.

- Copay with Prescription Savings Program:
  $5 for 90-day supply*
- Copay at Retail Pharmacy:
  $20 plus 50% of the TCC - maximum $200 out-of-pocket

PATIENT ASSISTANCE/COPAY ASSISTANCE COUPONS

The Plan has expanded prescription coverage to include MedBen Rx's Benefit Preservation Program, a multi-layered approach to improve patient care and deliver savings for members and the Plan. This program incorporates the use of Patient Assistance Programs and/or copay assistance coupons for eligible members.

After submitting a prescription under the Benefit Preservation Program, MedBen Rx will reach out to you directly to see if you qualify for any patient assistance and/or copay coupons. The representatives will discuss available options and help walk you through the enrollment process if eligible.

Be advised that the medications approved under this program may change throughout the year. If a drug is no longer eligible under the benefit preservation program, the Plan rules will apply.

If you have any questions or concerns about the program, contact MedBen Rx's Benefit Preservation Program at 1.877.393.0009 or email help@benefitspreservationprogram.com.

Who do I contact with questions about my prescription coverage?

Inquiring About:	Who To Contact:
Covered Benefits	MedBen Rx 1.888.633.2366
Eligibility/Adding a Dependent or other changes	Commissioners' Office Benefits Line 419.354.1373
Medical Necessity Review/Precertification	MedBen Rx 1.888.633.2366
Claim Payment/Denial	MedBen Rx 1.888.633.2366
New ID cards	MedBen Rx 1.888.633.2366

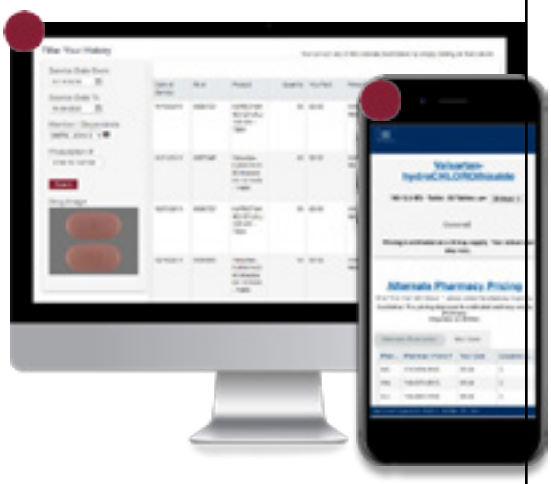
Member Prescription Portal

Log In to the Portal

To register visit MBAccess.MedBen.com and click on the "First time here? Register" link located in the home page. Select Participant/Insured and follow the steps to create your user name and password. Once registered you can click on the "View Rx Claims" icon.

Member Prescription Portal Features

My Benefits – Check prescription copays and learn about the Prescription Savings Program and how you can save on your medications.



Pharmacy Locator – Search for participating pharmacies.

Drug History – Review recent purchases by date range.

Request Card – Print/view a prescription card.

Drug Coverage – Search for a medication by name, dosage and frequency of use to see:

- Whether the drug is covered under your plan;
- Total drug cost, the portion the plan pays, and your cost; and
- Alternative pricing at nearby pharmacies.

Additionally, by clicking the "Alternatives" tab, you can view a list of drugs that are equivalent to the one you are being prescribed.

The Importance of Price Shopping for Medications

Drug companies charge different types of buyers (ex. wholesalers, pharmacy buying cooperatives, hospitals or hospital cooperatives, mail order vendors, etc.) different prices for the same product. This pricing also changes on a regular basis.

What can you do to save the most on your prescriptions?

The same is true for pharmacies - different pharmacies have different prices for the medications they dispense to you. With this in mind, comparing costs across different pharmacies is a vital step to saving money on your medications.

DENTAL COVERAGE

Total Monthly Cost

Single	$34.22
Family	$92.42

Employee Payroll Deduction
(1st & 2nd pay of month)

Single	$2.56
Family	$6.93
Spousal Premium in addition to family premium	$17.11

Annual Deductible
$ 100 Per Person

Annual Coinsurance
80/20% on Class II benefits

50/50% on Class III benefits

Maximum Annual Benefits
$1,500 Per Person

A predetermination of benefits is recommended if seeking services in excess of $200.

Class I: Covered annually at 100% of the Usual, Customary and Reasonable (UCR) fee and are not subject to the deductible:

- 2 cleanings
- 2 fluoride treatments
- 1 set of bitewing radiographs
- Sealants for children under 14 (limited)

Class II: Covered annually at 80% of the UCR fee after the deductible has been met:

- Radiographs (Full mouth x-rays are a benefit once in a five year period.)
- Oral Surgery
- Minor Restorative Services
- Periodontics
- Endodontics

Class III/IV: Covered at 50% of the UCR fee after the deductible has been met:

- Prosthodontics
- Major Restorative Services
- Orthodontics ($1,500 per person-per lifetime, to the end of the year in which they turn 19) not subject to deductible

For a complete listing of excluded and limited services refer to the Plan Document.

When searching for a dentist, choose a Delta Dental PPO provider.

Delta Dental has two networks of providers, Premier and PPO (Point-of-Service). You might think that choosing a Premier provider is the best option; however, a PPO provider offers the best savings for you and the Plan.

Sample Cost for an Adult Cleaning: $80 at a Delta Dental PPO or Premier Dentist

While participating dentists charge you the same amount for a cleaning, the Plan realizes an average savings of $23 per visit when you choose a PPO dentist over a Premier dentist.

DELTA DENTAL®

Find a participating dentist by logging in to the Delta Dental Member Portal at www.memberportal.com or by using Delta Dental's online Find a Dentist tool at www.deltadentaloh.com. Be sure to select a PPO provider for maximum savings.

In addition to finding PPO Dentists, the Member Portal provides easy, secure online access to your dental benefits information, 24/7. This mobile-friendly tool allows you to view eligibility, coverage details, claims information print ID cards, and more.

Sample Costs for a Crown:
$1,100 (covered at 50% coinsurance)

Sample Costs (not actual cost)	Delta Dental PPO Dentist	Delta Dental PREMIER Dentist
Dentist's agreed upon fee	$754	$988
Plan Payment	$377	$494
Amount You Pay	**$377**	**$494**

Both you and the Plan save when choosing a Delta Dental PPO Dentist.

Note: Payment examples given are illustrative only. Fees and reimbursements can vary by location and dentist.

VISION COVERAGE

Vision coverage is available to help offset costs for annual routine eye exams. Coverage may also be used to assist with payment of lenses, frames, contacts, and refractive surgery to correct refractive errors. Benefits are payable only as primary under this self-insured program

Total Monthly Cost

Single	$ 9.18
Family	$24.80

Employee Payroll Deduction
(1st & 2nd pay of month)

Single	$0.69
Family	$1.86
Spousal Premium: in addition to family premium	$4.59

$150 Reimbursement Limit for Covered Services received in the 2026 Benefit Period.

Coverage is limited to the services performed/prescribed by a physician.

Original detailed invoices and receipts are required and must be submitted with a Vision Services Claim form.

All 2025 claims must be submitted to your Insurance Group Representative by March 31, 2026, in order to qualify for the 2025 reimbursement limit. Any unused portion of the 2025 reimbursement is available for use in the 2026 benefit period for services received in 2026.

All 2026 vision claims must be submitted by March 31, 2027. Any unused portion of the 2026 reimbursement is available for use in the 2027 benefit period for services received in 2027.

See the Plan Document for additional information.

LIFE INSURANCE

Enrollment in the life insurance benefit is mandatory for benefit eligible employees and requires completion of the confidential Mandatory Wellness Screening for enrollment, even if waiving all other benefits.

$20,000 policy*

Total Monthly Cost* $ 8.54
Employee Payroll Deduction $0

* Board of DD Employees refer to the Life Certificate on the Employee Website.

Beneficiary designation will follow state designation unless noted on a Universal Application. Refer to the Employee Website to view the Life Insurance Certificate. Conversion options are available at time of separation and will be forwarded to employees with COBRA information.

PLAN STATUS REPORT

2026 Estimated Expenses: (as of 10/6/25)		$18,245,041
2025 Estimated Expenses: (as of 10/18/24)		$16,274,375
2025 Year to Date Expenses: (as of 10/31/25)		$13,030,782
2024 Plan Expenses:		$15,630,085
Medical:	$12,018,819	
Prescription:	$2,531,058	
Dental:	$534,631	
Vision:	$68,883	
Life:	$35,596	
Wellness:	$60,043	
Administrative:	$381,055	
2023 Plan Expenses:		$14,589,984
2022 Plan Expenses:		$13,061,339
2021 Plan Expenses:		$11,255,034
2020 Plan Expenses:		$11,173,315

As a self-insured plan, Wood County is not required to determine medical loss ratio.

Find it on the Web • www.woodcountyohio.gov

Get the most up-to-date information on the Employee Health Benefits Plan and Wellness Programs on the Employee Website.

- Network & Plan Administrator Information
- Plan Document & Plan Amendments
- Universal Application & Certification Forms
- Claim Forms
- OBRA Primary Election Form
- Mail Order Forms (Rx)
- Request for Medical Necessity Review (Rx)
- Annual Employee Insurance Meeting Presentations
- Privacy Practices/HIPAA forms including Authorization to Release Information
- COBRA Personnel Action Report
- Medicare Part D Information
- Summary of Benefits & Coverage and Definitions
- Marketplace Information

2026 Wellness Programs

YOU Matter!
Take a Step Toward Wellness

The key to lifestyle change begins with you. If you are ready to make a change, the wellness programs are here to help.

The wellness programs are designed to engage and motivate employees and their family members to be aware of their health status. Whether you choose to participate in the programs is completely up to you.

One of the best ways to be engaged in your health status is to have a primary care physician. This allows you to have a medical home to contact for common ailments instead of relying on urgent care or the emergency room for non-life threatening conditions.

Who Is Eligible

All employees, full and part time, can participate in the wellness challenges and events.

Benefit eligible employees (even if not enrolled in coverage) can also participate in the wellness screenings, earn credit toward their 2027 medical deductible and receive reimbursement for programs listed on page 21.

Employees who are interested but unable to participate in these programs due to work schedules or medical conditions, can call the Benefits Line at 419.354.1373 or email wellness@woodcountyohio.gov for more information on how to participate.

Every Minute Counts!

This year you are encouraged to track active minutes just like you track your time at work. By submitting your time, you'll be eligible to win prizes throughout the year.

For most healthy adults, the Department of Health and Human Services recommends these exercise guidelines:

- Aerobic Activity: Get at least 150 minutes of moderate aerobic activity a week. Think brisk walking, push mowing the lawn, biking, etc.
- Strength Training: Do strength training for all major muscle groups at least two times per week. You don't need weight machines to get a workout. Your own body weight and resistance bands can be just as effective.

As a general goal, aim for at least 30 minutes of moderate physical activity every day. According to the Mayo Clinic, cutting down on sitting time is important, too. The more hours you sit each day, the higher your risk of metabolic problems.

Short on long blocks of time? Even brief bouts of activity offers benefits. Any activity is better than none at all. What's important is making regular physical activity part of your lifestyle.

EARN A DEDUCTIBLE CREDIT

Benefit eligible employees can earn a medical deductible credit for the 2027 plan year by submitting bi-weekly "timesheets" to track active minutes and "overtime" from wellness events and EAP webinars. To earn the credit, you must also complete a wellness screening during 2026, plus you'll earn 60 minutes of overtime for doing so.

Visit the employee website to download the timesheet and submit your activity. The first timesheet starts on January 11. Each timesheet will offer some wellness tips and a few challenges to encourage you to get moving.

Active Minutes	Deductible Credit
5,000	$25
6,500	$50
8,000	$75
9,500	$100

Overtime

Events are also available to help boost your total minutes. Earn 60 minutes for viewing the featured 2026 EAP Webinars and 30 minutes for each 2026 lunch and learn program. Other overtime events will be offered throughout the year. Just submit proof of attendance and track your overtime on your timesheet to earn the credit.

Wellness Awareness Screening: Know Your Numbers!

The free, confidential screenings include a health risk assessment, coronary risk profile, A1C, blood pressure, bone density, and optional PSA and occult blood screenings. Benefit eligible employees and their family members over the age of 18 can participate. Screenings are required for all employees prior to enrollment in the Plan and also for their spouses if enrolling in the Plan as either primary or secondary.

Appointments are available year round at the Wood County Hospital. Email wellness@woodcountyohio.gov to register.

These screenings are not meant to replace annual physicals by your health care provider. However, if you are already seeing your physician on an annual basis, consider participating in this screening prior to meeting with your physician as a lower cost alternative for yourself and the Plan.

Results of the individual screenings are not shared with the Plan; however the Plan does receive an aggregate summary of the health screening and assessment results based on all participants. These results help plan future wellness programming.

Individuals who do not provide the required 24-hour cancellation notice for scheduled visits or who do not report to their appointment will be charged $15 for missed appointments. All screenings must be completed by December 18, 2026.

Having high blood pressure, cholesterol and blood sugar may have few, if any, symptoms. The only way to know your levels is to measure them.

Here are the four types of numbers everyone should know — and why.

BLOOD PRESSURE

Your healthy target: 120/80 mm Hg or less

Why it matters: Your blood pressure is the force of your blood pushing against the walls of your arteries. If it's too high, your heart has to work harder. Over time, high blood pressure can cause your heart to enlarge or weaken. This can lead to heart failure. High blood pressure can also narrow your arteries, which disrupts proper blood flow to your heart or brain and can trigger a heart attack or stroke.

BLOOD CHOLESTEROL

Your healthy target: Total cholesterol lower than 200 mg/dL

- LDL - less than 100 mg/dL
- HDL - men greater than 50 mg/dL;
  - women greater than 50 mg/dL with the goal to be above 60 mg/dL
- Triglycerides – should be under 150 mg/dL

Why it matters: Cholesterol is a fatty substance found in your body's cells. It helps your body make important vitamins and hormones. But too much cholesterol can lead to plaque buildup inside your blood vessels. This sticky substance causes your arteries to harden and narrow, which limits blood flow. These blockages can trigger a heart attack or, if they're located in the brain, a stroke.

A1C - BLOOD GLUCOSE

Your healthy target: Below 5.7%;

- Levels of 5.7% to 6.4% point to prediabetes
- Anything above 6.5% falls into the diabetic range

Why it matters: Your body breaks down food into glucose, which cells absorb for energy. When this process goes awry, glucose builds up in the blood. Extra sugar in your bloodstream is a sign of diabetes, a disease that can harm every organ in your body, while also damaging nerves and blood vessels.

BODY MASS INDEX

Your healthy target: 18.5 to 24.9

Why it matters: Your BMI is a weight-height calculation that can help determine if you're overweight or obese. Excess body fat increases your risk for a wide range of health problems, including high blood pressure, heart disease, type 2 diabetes and sleep apnea. A BMI over 30 is especially dangerous to your overall health.

REIMBURSEMENT PROGRAMS

Benefit eligible employees may receive retroactive reimbursement for the programs noted below. Refer to the employee website for required forms and submission deadlines.

Fitness Program

Provides reimbursement for gym memberships and fitness classes based on 30-visit minimum utilization per six month reimbursement period. Participants may combine eligible fitness classes to obtain the minimum utilization requirements. Criteria for fitness facilities/ programs is posted on the Employee Website. On-line subscriptions are not eligible for reimbursement under this program.

Reimbursement Periods: January 1 — June 30
July 1 — December 31

Utilization Requirement & Maximum Reimbursement per Period:

0 - 29 Visits	No Reimbursement Available
30 - 59 Visits	$75 per person
60 + Visits	$150 per person

Summer Swim

Provides reimbursement for individuals and families who purchase a season pass at local public swimming pools during the summer months.

Reimbursement Period: May through September
Utilization Requirement: 20 Visits
Maximum Reimbursement: $50 per person

Tobacco Termination

Provides reimbursement for the cessation method of choice including prescription medication that is excluded under the prescription coverage, hypnosis, acupuncture, etc. outside of the free Ohio Quit Line.

This program also requires two sessions with an EAP counselor. Contact the Employee Assistance Program at 1.800.607.1522 to schedule appointments. Reimbursement may also be eligible with proof of enrollment in the Ohio Quit Line Program.

Reimbursement Maximum: $150 per qualified participant per year

Employee Only Programs

Benefit eligible employees can get reimbursed for their participation in the following programs. Reimbursement for these programs will be processed quarterly.

Email wellness@woodcountyohio.gov prior to purchase if you have questions regarding qualifying programs.

Community Sponsored Fitness Events

Receive up to $30 reimbursement for participating in a 5K, duathlon/ triathlon, marathons, etc. Reimbursement is limited to two events per year.

On-Line Nutritional/Fitness Programs

Includes Weight Watchers online, Noom, BODi, Peloton, etc. Requires completion of the annual Wellness Screening. The purchase of the on-line program must occur within the same year as the screening. Reimbursement is limited to a maximum of $50 per year.

Program information is communicated on the wellness page of the Employee Website. Questions regarding reimbursable expenses can be directed to the Benefits Line at 419.354.1373 or emailed to wellness@woodcountyohio.gov.

The Plan does not reimburse for ancillary services not included in the membership fee (i.e., food/drinks, tanning, massages, supplies, child care, etc.), recreational teams, individual sports programs or programs covered by insurance.

The amount reimbursed shall not exceed the amount paid to the facility/program for the specified period.

Reimbursement for the Fitness and Summer Swim Program is based on each benefit eligible participant that meets the utilization requirement during the specified period to a maximum of three members per family. Only one visit per day will count for utilization purposes.

Programs are funded by the Employee Health Benefits Plan through collected premiums. As required by the IRS, taxable fringe benefits may apply to reimbursements and prizes. Employees seeking reimbursement must be eligible for coverage at the time of reimbursement.

FINANCIAL WELLNESS

Just like your physical wellbeing, financial wellbeing is also important. If you're feeling stressed about your finances help is out there.

Making the most of your money starts with five building blocks for managing and growing your money -- The MyMoney Five. Keep these five principles in mind as you make day-to-day decisions and plan your financial goals.

See MyMoney.gov to learn more about the five principles. The site also offers budgeting worksheets, checklists, and calculators.

DEFERRED COMPENSATION

Making sure you have enough saved up at retirement is an important part of financial wellness. Your OPERS benefit is not designed to replace 100% of your pre-retirement income. That's why deferred compensation offers a simple, flexible way for you to save for retirement.

Wood County offers two deferred compensation programs:

- Ohio County Employees Retirement Plan (Empower)
- Ohio Deferred Compensation

Both programs offer contributions through payroll deduction with as little as $10 per pay required to get started. Enrolling is easy just contact the representative listed on the back page of this document.

Ohio Tobacco Program

Quit Line: 1-800-QUIT-NOW

Tobacco use is the single most preventable cause of death and disease in the nation and in Ohio. It is estimated that smoking costs Ohio – its employers and insurers - more than $9 billion in health care costs and productivity losses each year. With the right tools, Ohioans can quit using tobacco – and stay quit.

The Quit Line serves as one of the most effective means for curbing smoking rates in Ohio – and is available free of charge. Callers to the Ohio Tobacco Quit Line are five times more likely to successfully quit smoking than people who quit cold turkey.

If you are ready to quit tobacco, but want to make sure that you have the resources and support necessary for success, the Quit Line can help. Designated, experienced "quit specialists" are assigned to each person who enrolls in the program and can help set a quit date and design a quit plan that matches your tobacco use habits.

OPEN SWIM AT THE BOARD OF DD THERAPY POOL

The Board of DD's Nichols Therapy Pool has staff swim time on Tuesdays and Thursdays from 4:15 to 5:15 p.m. The pool is open year round, except for July when it is closed for pool maintenance.

Check the Board of DD Facebook page for cancellations and other updates.

HAVE KIDS IN SPORTS?

Delta Dental offers a discounted rate on their athletic mouth guard. An assortment of colors are available.

Use Code: DDOH at checkout for 50% off all products at DentalDental.com

Acentra HEALTH | EMPLOYEE ASSISTANCE PROGRAM

Acentra Health Employee Assistance Program (EAP) is a complimentary service available to you through your employer. The EAP provides counseling sessions at no cost to you, as well as a wide variety of services to enhance overall wellbeing and support healthy work-life balance. Services and commonly addressed issues are described below. The program is completely confidential. **Call anytime to learn more or to get started.**

EAP Products and Services

Immediate 24/7 Support & Guidance

Toll-Free Phone: 1.800.607.1522
EAP Website: www.EAPHelplink.com
Company Code: WEBEAP

Solutions-Focused Counseling

Whether you are dealing with stress, or issues with relationships, parenting, substance abuse, and more, we can help. Let us help connect you with a highly qualified counselor for in-person, phone, or video sessions. You are eligible for up to 5 free confidential counseling sessions per issue, per year.

Legal & Financial Services

Legal and financial concerns can be stressful, complicated, and time-consuming. Reach out today for a free 30-minute consultation with an attorney or Money Coach, per each legal or financial matter, per year. Should you choose to retain the professional you will receive 25% off the regular rate.

Caregiver Support Services

Are you looking for childcare, summer camps, afterschool activities, back-up care, or more? Need help finding referrals for assisted living facilities or in-home care for an older parent? We can help. Reach out to speak to one of our Childcare or Eldercare Specialists, available 24/7. In addition to referrals, they can offer expert advice and guidance tailored to your area of need.

Work-Life & Convenience Services

Let us do the leg work when it comes to researching fitness centers, colleges, adoption services, relocation services, volunteer opportunities, pet care, entertainment, doctors, home repair services, and so much more. Your time is too valuable; our research team is standing by to do the work for you.

Website Tools & Resources

Your EAP website is your one-stop resource for tools, articles, webinars, educational videos, legal forms, financial calculators, self-serve look-ups, and more. Your website and code is listed above.

Savings Center

Also through the EAP website, you can access the Savings Center. This is a discount shopping program that is provided through the Perks At Work website. It offers discounts of up to 25% on name brand, practical, and luxury items, and access to free online classes.

Wood County Employee Health Benefits

2026 Plan Administrator Information

Eligibility and enrollment questions can be directed to the Benefits Line at 419.354.1373 or email benefits@woodcountyohio.gov.

Medical Insurance

Group Number: 19238-XXX (XXX = sub-group no.)

Third Party Administrator/Claims Processor
Meritain Health 1.800.925.2272 • www.meritain.com
Mon. - Fri. 8 a.m. to 5 p.m.

Network (Participating Providers & Medical Facilities)
FrontPath Health Coalition
419.891.5206 • www.frontpathcoalition.com
Mon. - Fri. 8:30 a.m. to 5 p.m.

Pre-Certification & Medical Management (Medical Manager)
Meritain Health Medical Management - 1.800.242.1199

Claims Submission
FrontPath Paper Claims: PO Box 5810; Troy, MI 48007-5810
include Group Number 19238 to expedite payment
Electronic Claims: FrontPath Coalition: EDI: Emdeon 34171

Appeals
Check the Explanation of Benefits for appeal time lines.
Submit to: Appeals Department, Meritain Health,
PO Box 660908, Dallas TX 75266-0908

Prescription Insurance

Group Number: 10615-XXX

Pharmacy Benefits Manager/Claims Processor
MedBen Rx - 1.888.633.2366
Mon. – Fri. 8 a.m. to 6:30 p.m.
MBaccess.MedBen.com

Claims Submission: RX Bin 018893 (PCN: MEDB),
Ventegra, Inc. 10400 Overland Road Box #353 Boise, ID 83709

Prescriptions over $1,000 (including outpatient injectables and infusions) require medical necessity review. See the Employee Website for the Medical Necessity Review form.

Mail Order Program
Postal Prescription Services (PPS)
1.800.552.6694
Mon. – Fri. 6 a.m. to 6 p.m. Sat. 9 a.m. to 2 p.m. PST
www.ppsrx.com
Claims Submission: PO Box 2718, Portland, OR 97208-2718

Optional Programs Available to Employees

Payroll deduction is available for the following programs.

Enrollment is managed through the contacts listed below.

Ohio Deferred Compensation Program:
Stan Mories moriess@nationwide.com 419.560.0644
Ohio457.org

Ohio County Employees Retirement Plan (Deferred Compensation):
Kevin Pietro kevin.pietro@empower.com
303.737.7269 OCERP457.com

AFLAC: Charles Polizano charles_polizano@us.aflac.com
419.409.1336

Vision Services Plan

Group Number: XXX

Administrator/Claims Processor
Commissioners' Office
Benefits Line: 419.354.1373
benefits@woodcountyohio.gov
Confidential Fax: 419.353.7429
Mon. - Fri. 8:30 a.m. to 4:30 p.m.

See your Insurance Group Rep. for claims submission and questions.

Dental Insurance

Group Number: 1395-1XXX

Administrator/Claims Processor
Delta Dental of Ohio
1.800.524.0149
Automated inquiry system is available 24/7 and can answer most questions
Customer service representatives are available Mon. – Fri. 8:30 a.m. to 8 p.m.
www.deltadentaloh.com

Claims Submission:
Delta Dental of Ohio, PO Box 9085
Farmington Hills, MI 48333-9085

Life Insurance

Administrator/Claims Processor
MetLife

Plan Trustees

Board of County Commissioners
419.354.9100

General Information

The Plan Document, amendments, and forms are available to view or download from the Employee Website, www.woodcountyohio.gov.

Acentra

Employee Assistance Program
1.800.607.1522
www.eaphelplink.com
Company Code: WEBEAP
Free & Confidential
Available 24/7/365