Employee Insurance Orientation

Overview of the Enrollment Process for New Employees

Benefit Eligibility

Employees ● Spouses ● Dependents

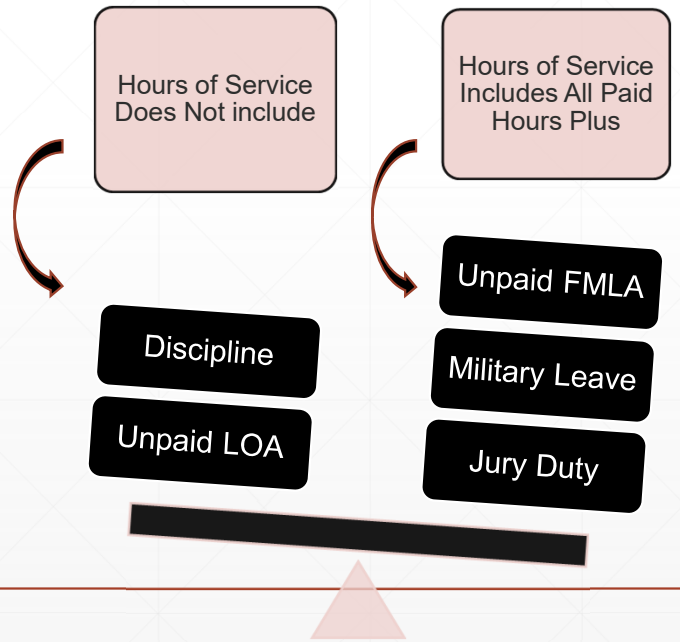
DETERMINING EMPLOYEE ELIGIBILITY FOR THE PLAN

Full Time (ACA) is defined as 30 Hours of Service or more per week, non-seasonal

Based on Hours of Service: Hours worked + Paid leave

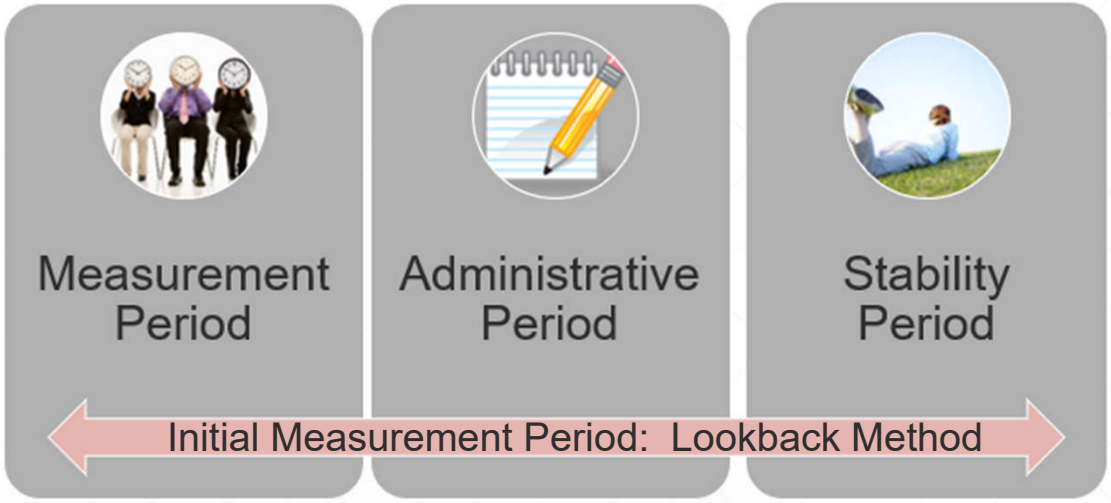
Full Time for Wood County is 40 hours per week

Vacation/Holiday eligible



Non Benefit-Eligible Employees

- Sign-Off on Non-Benefit Eligible Status
  - Communicates when Initial Measurement Period Ends
  - Wellness Waiver Sign-Off
- Marketplace Notice
- Health Benefits Guide Access on-line



Looks at first full 26 consecutive pay periods to determine hours of service

1,560 Hours during Measurement Period = Benefit Eligible for Stability Period

Benefit-Eligible Employee - Blue Folder

- Health Benefits Guide
- Benefit-Eligible Insurance Checklist
- Universal Application
- Certification Forms – Spousal/Dependent/OBRA
- Mandatory Wellness Screening Information
- Wellness Waiver
- Flyers from Vendors
  - FrontPath Health Coalition (Medical Network)
  - Meritain Health (Medical Claims Processor)
  - MedBenRx
  - Delta Dental
  - Rx Mail Order – Kroger PPS
- Vision Claim Form
- Employee Assistance Program Information
- Deferred Compensation Programs
- Marketplace Notice
- HIPAA Privacy Notice/Initial COBRA Notice
- AFLAC – Supplemental Insurance (optional)

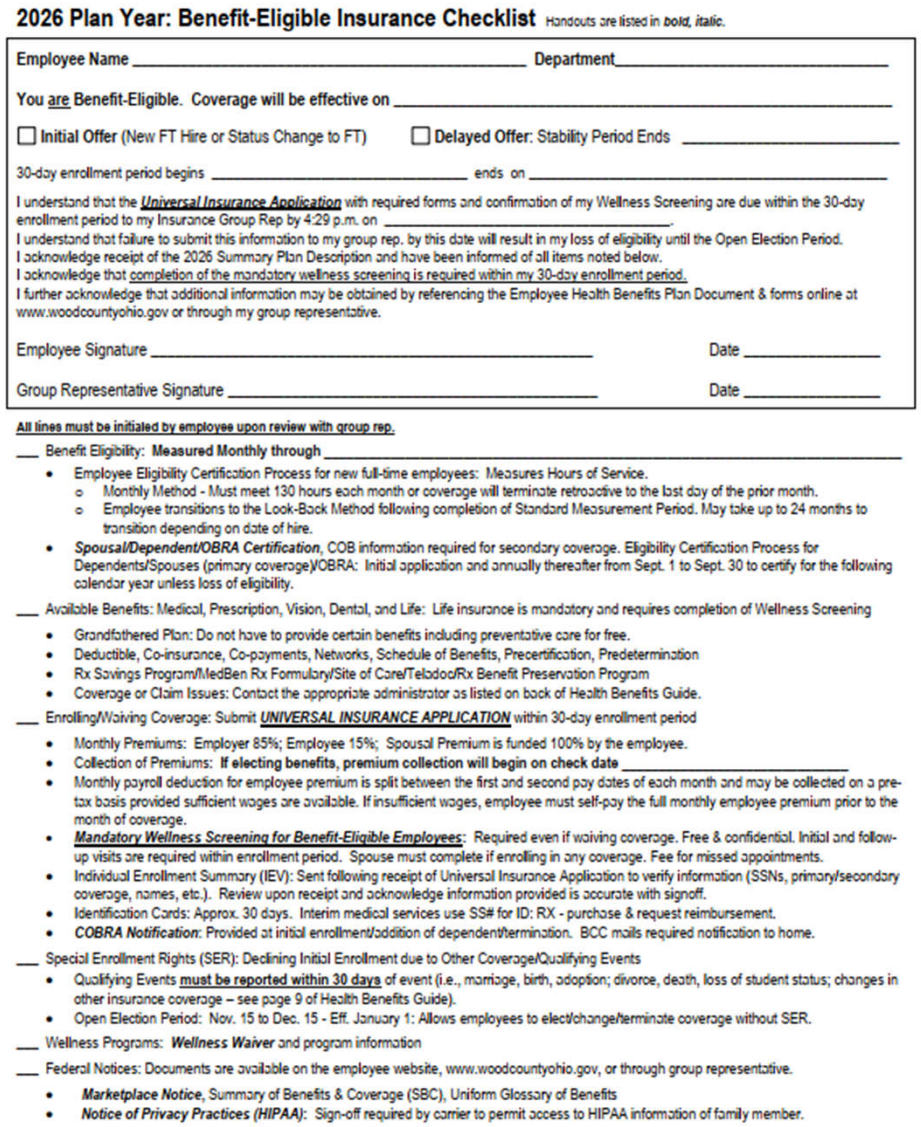
30-Day Waiting Period/Enrollment Period Applies
Coverage effective first day of next month

NOTICE

Enrollment Period begins at time of hire or change to benefit-eligible status

All forms and wellness screening must be completed during this 30-day period

Failure to submit required enrollment information will result in loss of eligibility until the Open Election Period.



2026 Plan Year: Benefit-Eligible Insurance Checklist Handouts are listed in *bold, italic.*

Employee Name _____ **Department**_____

You are Benefit-Eligible. Coverage will be effective on _____

☐ **Initial Offer** (New FT Hire or Status Change to FT) ☐ **Delayed Offer:** Stability Period Ends _____

30-day enrollment period begins _____ ends on _____

I understand that the ***Universal Insurance Application*** with required forms and confirmation of my Wellness Screening are due within the 30-day enrollment period to my Insurance Group Rep by 4:29 p.m. on _____.
I understand that failure to submit this information to my group rep. by this date will result in my loss of eligibility until the Open Election Period.
I acknowledge receipt of the 2026 Summary Plan Description and have been informed of all items noted below.
I acknowledge that completion of the mandatory wellness screening is required within my 30-day enrollment period.
I further acknowledge that additional information may be obtained by referencing the Employee Health Benefits Plan Document & forms online at www.woodcountyohio.gov or through my group representative.

Employee Signature _____ Date _____

Group Representative Signature _____ Date _____

All lines must be initialed by employee upon review with group rep.

___ Benefit Eligibility: **Measured Monthly through** _____

- Employee Eligibility Certification Process for new full-time employees: Measures Hours of Service.
  - Monthly Method - Must meet 130 hours each month or coverage will terminate retroactive to the last day of the prior month.
  - Employee transitions to the Look-Back Method following completion of Standard Measurement Period. May take up to 24 months to transition depending on date of hire.
- ***Spousal/Dependent/OBRA Certification***, COB information required for secondary coverage. Eligibility Certification Process for Dependents/Spouses (primary coverage)/OBRA: Initial application and annually thereafter from Sept. 1 to Sept. 30 to certify for the following calendar year unless loss of eligibility.

___ Available Benefits: Medical, Prescription, Vision, Dental, and Life: Life insurance is mandatory and requires completion of Wellness Screening

- Grandfathered Plan: Do not have to provide certain benefits including preventative care for free.
- Deductible, Co-insurance, Co-payments, Networks, Schedule of Benefits, Precertification, Predetermination
- Rx Savings Program/MedBen Rx Formulary/Site of Care/Teladoc/Rx Benefit Preservation Program
- Coverage or Claim Issues: Contact the appropriate administrator as listed on back of Health Benefits Guide.

___ Enrolling/Waiving Coverage: Submit ***UNIVERSAL INSURANCE APPLICATION*** within 30-day enrollment period

- Monthly Premiums: Employer 85%; Employee 15%; Spousal Premium is funded 100% by the employee.
- Collection of Premiums: **If electing benefits, premium collection will begin on check date** _____
- Monthly payroll deduction for employee premium is split between the first and second pay dates of each month and may be collected on a pre-tax basis provided sufficient wages are available. If insufficient wages, employee must self-pay the full monthly employee premium prior to the month of coverage.
- ***Mandatory Wellness Screening for Benefit-Eligible Employees***: Required even if waiving coverage. Free & confidential. Initial and follow-up visits are required within enrollment period. Spouse must complete if enrolling in any coverage. Fee for missed appointments.
- Individual Enrollment Summary (IEV): Sent following receipt of Universal Insurance Application to verify information (SSNs, primary/secondary coverage, names, etc.). Review upon receipt and acknowledge information provided is accurate with signoff.
- Identification Cards: Approx. 30 days. Interim medical services use SS# for ID: RX - purchase & request reimbursement.
- ***COBRA Notification***: Provided at initial enrollment/addition of dependent/termination. BCC mails required notification to home.

___ Special Enrollment Rights (SER): Declining Initial Enrollment due to Other Coverage/Qualifying Events

- Qualifying Events **must be reported within 30 days** of event (i.e., marriage, birth, adoption; divorce, death, loss of student status; changes in other insurance coverage – see page 9 of Health Benefits Guide).
- Open Election Period: Nov. 15 to Dec. 15 - Eff. January 1: Allows employees to elect/change/terminate coverage without SER.

___ Wellness Programs: ***Wellness Waiver*** and program information

___ Federal Notices: Documents are available on the employee website, www.woodcountyohio.gov, or through group representative.

- ***Marketplace Notice***, Summary of Benefits & Coverage (SBC), Uniform Glossary of Benefits
- ***Notice of Privacy Practices (HIPAA)***: Sign-off required by carrier to permit access to HIPAA information of family member.

BENEFIT ELIGIBLE CHECKLIST

Communicates:

- Coverage Effective Date
- Offer Type
- 30- Day Enrollment Period End Date
- Measurement Period Date
- Premium Effective Date

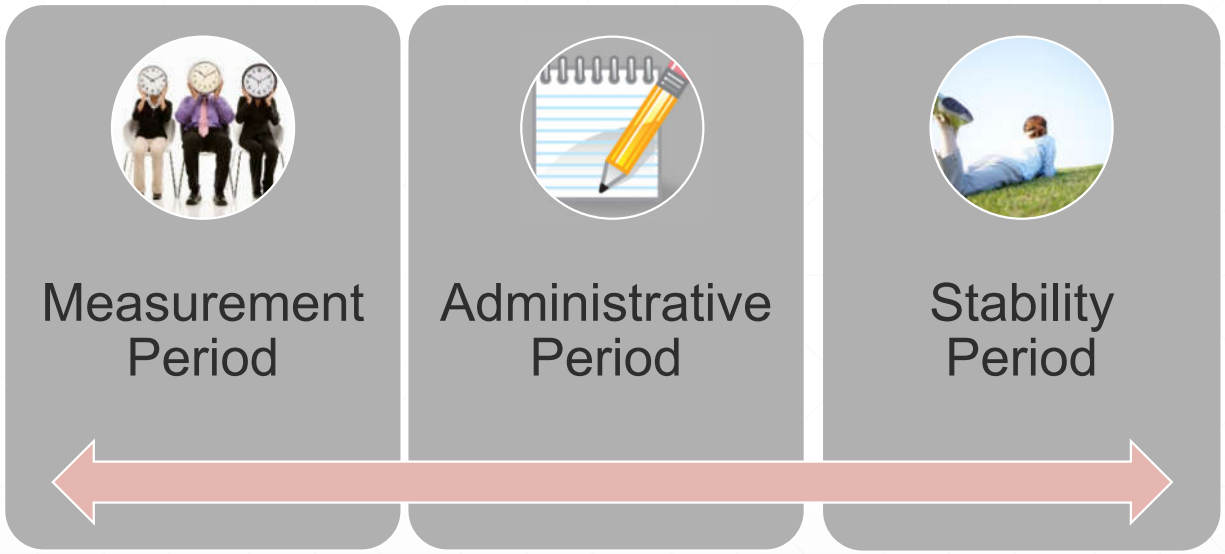
Employee must sign and initial all lines as reviewed with Group Rep.

Full Time: Monthly Measurement Method

Looks at employee's hours each month until placed in a Standard Stability Period.

- Hours measured each month to determine on-going eligibility (130 paid hours per month)
  - Eligibility may change monthly based on hours of service
  - If not meeting 130 hours – retro term to the first of the month in which hours were not met
- Transition to Look-Back Method following completion of full Standard Measurement Period
  - May take up to 24 months for transition – Depends on hire date during calendar year.

Ongoing Eligibility: Standard Look-Back Method



Standard Look Back Method

- ALL employees' hours are measured each year
  - Standard Look-back Method (Oct-Oct)
  - Coverage offered for next calendar year if full time

Spousal Eligibility

- Employees seeking primary coverage for a spouse must certify spousal income to determine eligibility. Annual certification is also required (Sept. 1 to 30).
- Spouse seeking primary or secondary coverage under any benefit must complete a wellness screening during the employee's 30-day enrollment period.

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

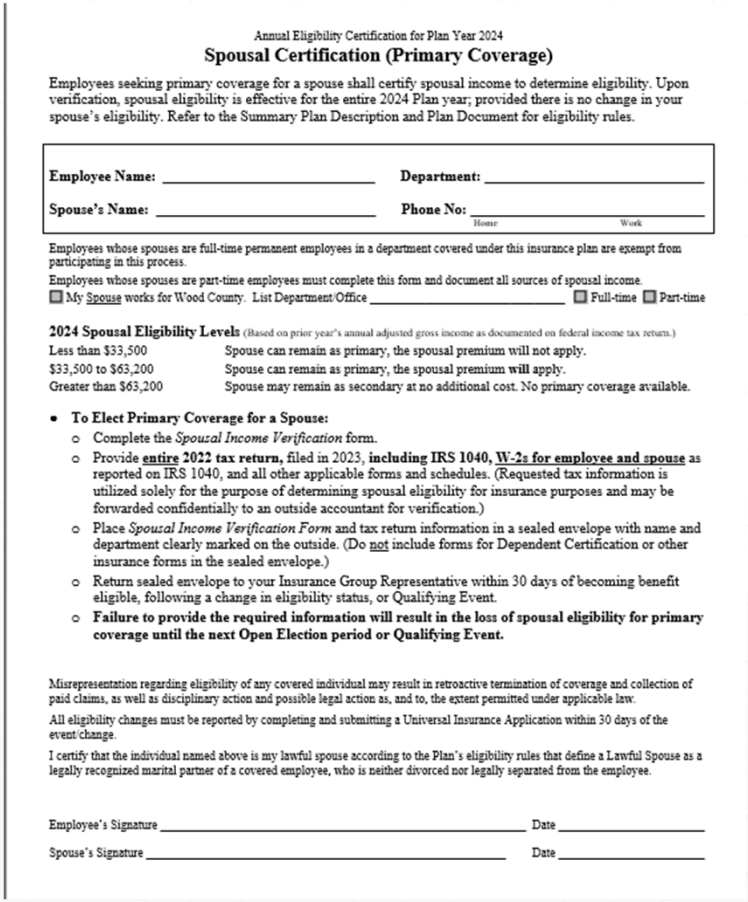
Primary insurance information must be submitted in order to enroll in secondary coverage.

Spousal Premium Rates

- Refer to the Spousal Eligibility section on Page 5 in the Health Benefits Guide 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 available on a pre-taxed basis.

Health & Prescription	$873.00
Vision	$9.18
Dental	$34.22

Spousal Certification Forms (Sample)



Annual Eligibility Certification for Plan Year 2024

Spousal Certification (Primary Coverage)

Employees seeking primary coverage for a spouse shall certify spousal income to determine eligibility. Upon verification, spousal eligibility is effective for the entire 2024 Plan year; provided there is no change in your spouse's eligibility. Refer to the Summary Plan Description and Plan Document for eligibility rules.

Employee Name: _____ **Department:** _____

Spouse's Name: _____ **Phone No:** _____ (Home / Work)

Employees whose spouses are full-time permanent employees in a department covered under this insurance plan are exempt from participating in this process.

Employees whose spouses are part-time employees must complete this form and document all sources of spousal income.

☐ My Spouse works for Wood County. List Department/Office _____ ☐ Full-time ☐ Part-time

2024 Spousal Eligibility Levels (Based on prior year's annual adjusted gross income as documented on federal income tax return.)

Less than $33,500	Spouse can remain as primary, the spousal premium will not apply.
$33,500 to $63,200	Spouse can remain as primary, the spousal premium **will** apply.
Greater than $63,200	Spouse may remain as secondary at no additional cost. No primary coverage available.

- **To Elect Primary Coverage for a Spouse:**
  - Complete the *Spousal Income Verification* form.
  - Provide **entire 2022 tax return,** filed in 2023, **including IRS 1040, W-2s for employee and spouse** as reported on IRS 1040, and all other applicable forms and schedules. (Requested tax information is utilized solely for the purpose of determining spousal eligibility for insurance purposes and may be forwarded confidentially to an outside accountant for verification.)
  - Place *Spousal Income Verification Form* and tax return information in a sealed envelope with name and department clearly marked on the outside. (Do not include forms for Dependent Certification or other insurance forms in the sealed envelope.)
  - Return sealed envelope to your Insurance Group Representative within 30 days of becoming benefit eligible, following a change in eligibility status, or Qualifying Event.
  - **Failure to provide the required information will result in the loss of spousal eligibility for primary coverage until the next Open Election period or Qualifying Event.**

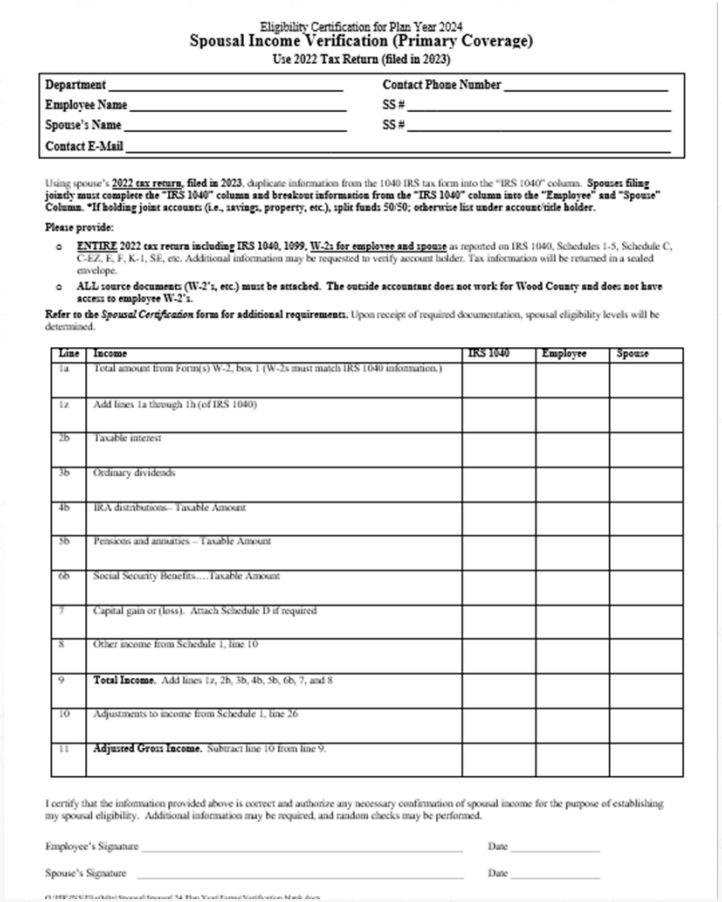
Misrepresentation regarding eligibility of any covered individual may result in retroactive termination of coverage and collection of paid claims, as well as disciplinary action and possible legal action as, and to, the extent permitted under applicable law.

All eligibility changes must be reported by completing and submitting a Universal Insurance Application within 30 days of the event/change.

I certify that the individual named above is my lawful spouse according to the Plan's eligibility rules that define a Lawful Spouse as a legally recognized marital partner of a covered employee, who is neither divorced nor legally separated from the employee.

Employee's Signature _____ Date _____

Spouse's Signature _____ Date _____



Eligibility Certification for Plan Year 2024

Spousal Income Verification (Primary Coverage)

Use 2022 Tax Return (filed in 2023)

Department _____ **Contact Phone Number** _____

Employee Name _____ **SS #** _____

Spouse's Name _____ **SS #** _____

Contact E-Mail _____

Using spouse's **2022 tax return, filed in 2023**, duplicate information from the 1040 IRS tax form into the "IRS 1040" column. **Spouses filing jointly must complete the "IRS 1040" column and breakout information from the "IRS 1040" column into the "Employee" and "Spouse" Column. "If holding joint accounts (i.e., savings, property, etc.), split funds 50/50; otherwise list under account title holder.**

Please provide:

- **ENTIRE 2022 tax return including IRS 1040, 1099, W-2s for employee and spouse** as reported on IRS 1040, Schedules 1-5, Schedule C, C-EZ, E, F, K-1, SE, etc. Additional information may be requested to verify account holder. Tax information will be returned in a sealed envelope.
- **ALL source documents (W-2's, etc.) must be attached. The outside accountant does not work for Wood County and does not have access to employee W-2's.**

Refer to the *Spousal Certification* form for additional requirement. Upon receipt of required documentation, spousal eligibility levels will be determined.

Line	Income	IRS 1040	Employee	Spouse
1a	Total amount from Form(s) W-2, box 1 (W-2s must match IRS 1040 information.)			
1z	Add lines 1a through 1h (of IRS 1040)			
2b	Taxable interest			
3b	Ordinary dividends			
4b	IRA distributions– Taxable Amount			
5b	Pensions and annuities – Taxable Amount			
6b	Social Security Benefits….Taxable Amount			
7	Capital gain or (loss). Attach Schedule D if required			
8	Other income from Schedule 1, line 10			
9	**Total Income.** Add lines 1z, 2b, 3b, 4b, 5b, 6b, 7, and 8			
10	Adjustments to income from Schedule 1, line 26			
11	**Adjusted Gross Income.** Subtract line 10 from line 9.			

I certify that the information provided above is correct and authorize any necessary confirmation of spousal income for the purpose of establishing my spousal eligibility. Additional information may be required, and random checks may be performed.

Employee's Signature _____ Date _____

Spouse's Signature _____ Date _____

Dependent Certification

- Dependent Eligibility: Health & Prescription
  - Qualified dependents are eligible for coverage on the employee's family coverage from birth to the end of the month in which they turn 26 — includes biological son or daughter, adopted son or daughter (includes placement for adoption), stepson or daughter
- Dependent Eligibility: Vision & Dental
  - Dependent Certification Required for Dependents Ages 20 to 23
  - Recertify annually: September 1st – September 30th
  - Applies to next calendar year or Plan Year provided no change in eligibility
    - Must report if no longer attending college (graduation/non-returning student)

See Health Benefits Guide (Page 5) for full details and eligibility requirements.

Annual Eligibility Certification for Plan Year 2024

Dependent Certification

Employees seeking Vision or Dental coverage for a dependent between the ages of 20 and 23 shall certify dependent eligibility upon enrollment in the plan and on an annual basis. Upon verification, eligibility is permitted for the entire Plan year; provided the dependent continues to meet the Plan's eligibility rules.

Employee Name: _____ **Department:** _____

Dependent Name: _____ **Date of Birth:** _____ **Age in 2024:** ____

Eligibility Rule Verification for Dependent: (Check appropriate box)

Unmarried	☐ Yes	☐ No
Not employed on a regular full time basis	☐ Yes	☐ No
Dependent on the covered employee or the covered employee's Spouse for more than 50% of their financial support (or if a stepchild: wholly dependent on the covered employee for financial support)	☐ Yes	☐ No
Claimed for tax exemption purposes under Section 152 of the Internal Revenue Code	☐ Yes	☐ No
Full Time Student at an accredited school	☐ Yes	☐ No

Name of School: _____

Address: _____
Street/PO Box City State Zip

If you answered yes to all of these questions, your dependent is eligible for Dental and Vision coverage. Please have the school named above complete the Verification of Full Time Student Status below. A statement from the school's clearinghouse may also be submitted with this certification as proof of full time student status.

Full time student coverage continues only between semesters/quarters if the dependent is enrolled as a full time student in the next regular semester/quarter and maintains dependent status as defined by the Plan. If the dependent withdraws from school or graduates midyear, the dependent must be removed from the Plan by submitting a Universal Insurance Application and COBRA Personnel Action form. Refer to the Plan Document and Summary Plan Description for eligibility rules.

Misrepresentation regarding eligibility of any covered individual may result in retroactive termination of coverage and collection of paid claims, as well as disciplinary action and possible legal action as, and to, the extent permitted under applicable law.

All eligibility changes, including mid-year graduations must be reported by completing and submitting a Universal Insurance Application within 30 days of the event/change to your insurance group representative.

I certify that the dependent named above, is considered a dependent based upon this Plan's current eligibility rules. I also authorize the school listed above to verify and/or release any information necessary to confirm full-time attendance for the purpose of establishing student status for the Dependent listed above.

Employee's Signature _____ Date _____

Dependent's Signature _____ Date _____

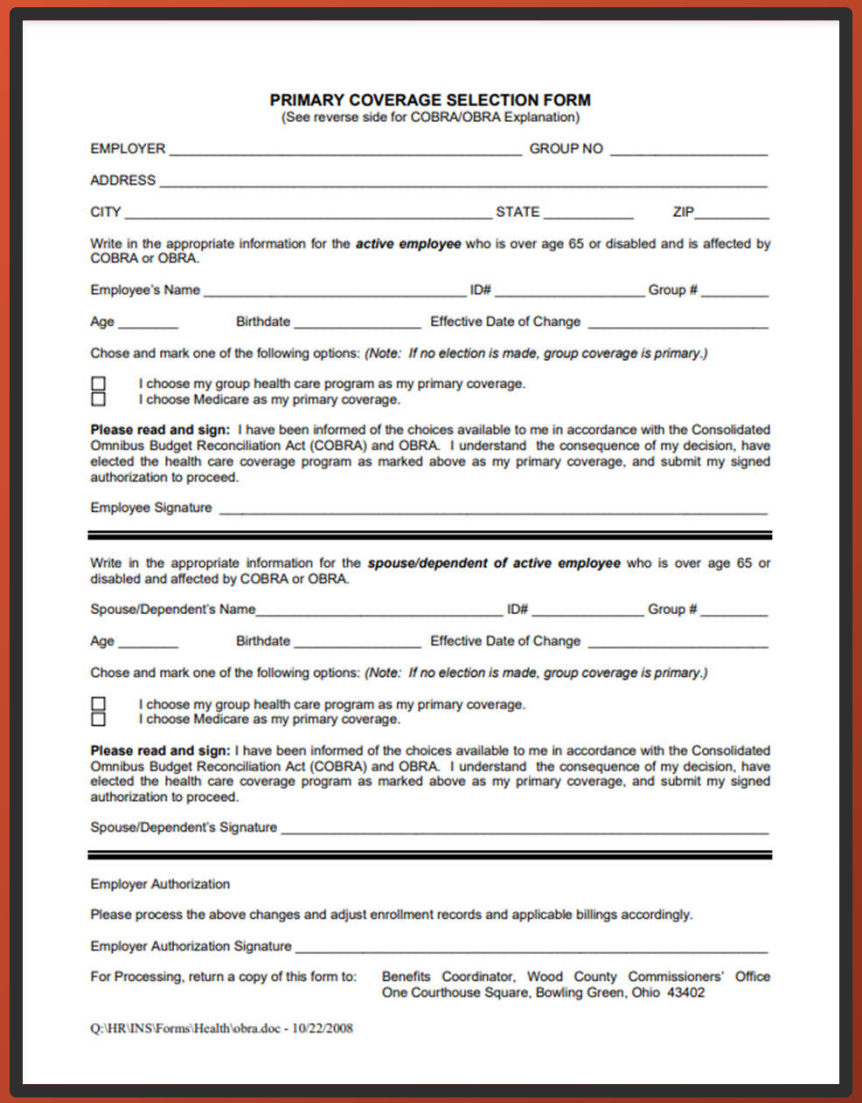
FOR SCHOOL USE ONLY: **SCHOOL STAMP**

Verification of Full Time Student Status

Please confirm the above noted Dependent's registration/enrollment at your institution:

Dependent Certification

Employee's seeking Vision or Dental coverage for a dependent between the ages of 20-23 must complete the Certification Process.



PRIMARY COVERAGE SELECTION FORM
(See reverse side for COBRA/OBRA Explanation)

EMPLOYER _____ GROUP NO _____

ADDRESS _____

CITY _____ STATE _____ ZIP_____

Write in the appropriate information for the ***active employee*** who is over age 65 or disabled and is affected by COBRA or OBRA.

Employee's Name _____ ID# _____ Group # _____

Age _____ Birthdate _____ Effective Date of Change _____

Chose and mark one of the following options: *(Note: If no election is made, group coverage is primary.)*

☐ I choose my group health care program as my primary coverage.
☐ I choose Medicare as my primary coverage.

Please read and sign: I have been informed of the choices available to me in accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) and OBRA. I understand the consequence of my decision, have elected the health care coverage program as marked above as my primary coverage, and submit my signed authorization to proceed.

Employee Signature _____

Write in the appropriate information for the ***spouse/dependent of active employee*** who is over age 65 or disabled and affected by COBRA or OBRA.

Spouse/Dependent's Name_____ ID# _____ Group # _____

Age _____ Birthdate _____ Effective Date of Change _____

Chose and mark one of the following options: *(Note: If no election is made, group coverage is primary.)*

☐ I choose my group health care program as my primary coverage.
☐ I choose Medicare as my primary coverage.

Please read and sign: I have been informed of the choices available to me in accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) and OBRA. I understand the consequence of my decision, have elected the health care coverage program as marked above as my primary coverage, and submit my signed authorization to proceed.

Spouse/Dependent's Signature _____

Employer Authorization

Please process the above changes and adjust enrollment records and applicable billings accordingly.

Employer Authorization Signature _____

For Processing, return a copy of this form to: Benefits Coordinator, Wood County Commissioners' Office
One Courthouse Square, Bowling Green, Ohio 43402

Q:\HR\INS\Forms\Health\obra.doc - 10/22/2008

OBRA SELECTION FORM
Age 65 or disabled

- OBRA law requires employees 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.
- Employees must report their election on the Primary Coverage Selection Form (OBRA) which is available on the employee website. The Plan is subject to Medicare regulations.
- See page 5 of the Health Benefits Guide

Available Benefits

Medical/Prescription ● Vision ● Dental ● Life

Plan Structure

Self-Insured

Non-Federal Governmental

Non-ERISA

Meets Affordability & Minimum Standards

GRANDFATHERED PLAN

Not all provisions of the ACA apply
(e.g., preventative care at no cost)

Eligible Medical Expenses

Medical Schedule of Benefits

- Services must be medically necessary due to illness or injury
- Limitations may apply

Predetermination of Benefits

- If unsure, request a Predetermination of Benefits through Meritain's customer service
- Process may take 15 to 30 business days to complete
- Predetermination is separate from Precertification requirements under the plan

Precertification Requirements

Services that require precertification are listed on the back of your medical ID card along with the required timeframe to complete the precertification.

Medical:

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

Prescription:

Medical Necessity Review prior to receiving prescriptions over $1,000 and outpatient infusions/injections.

FrontPath Health Coalition

Medical Network

In-Network

- Contractual agreement that determines the rate paid to the provider. Member cannot be billed for the difference.

Out-of-Network

- Member may be billed for the difference between the billed amount and the allowed amount.

My provider is offering a discount if I pre-pay for services.

Should I take advantage of this discount?

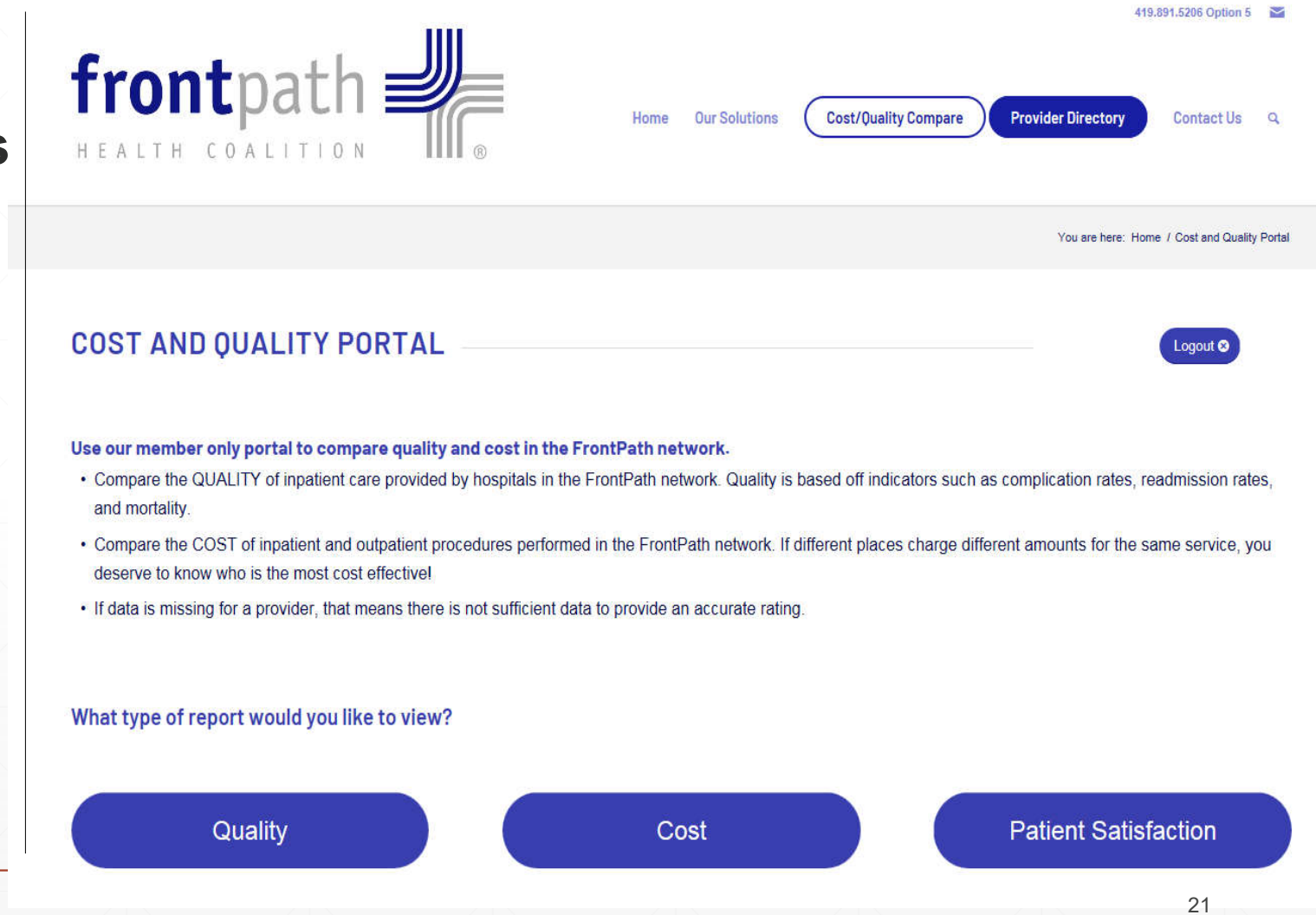
It is not recommended that you pay for services before the claim has been fully adjudicated by the plan administrator as it could result in you paying more than required by the Plan.

Choose Quality Network Providers

www.frontpathcoalition.com

You wouldn't trust just anyone to watch your kids or remodel your house. Would you?

Doesn't your health deserve the same considerations?



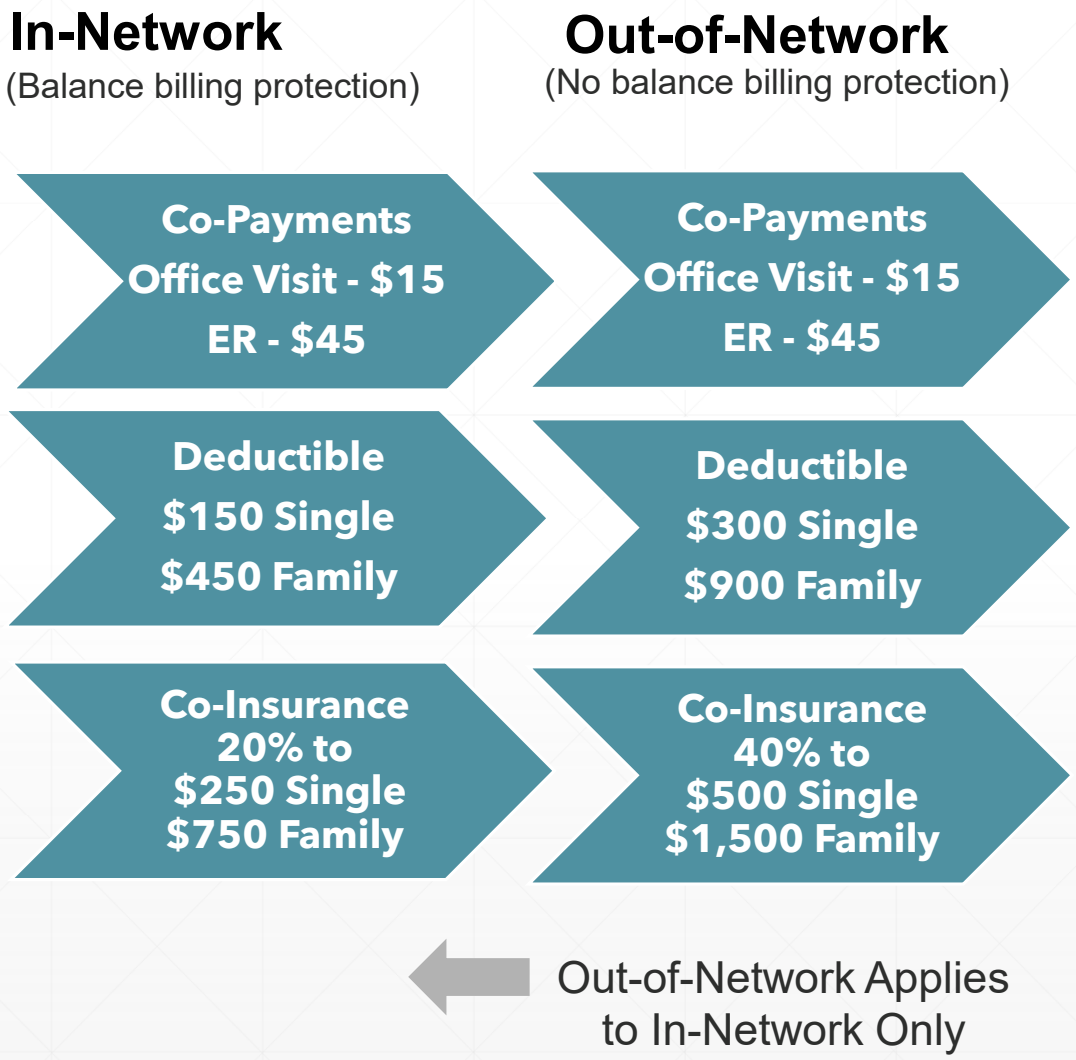
MEDICAL COVERAGE

Questions about an EOB?
Contact Meritain

- 1.800.925.2272
- meritain.com
- Mobile access available

Questions about a provider?
Contact FrontPath

- 1.888.232.5800
- Frontpathcoalition.com



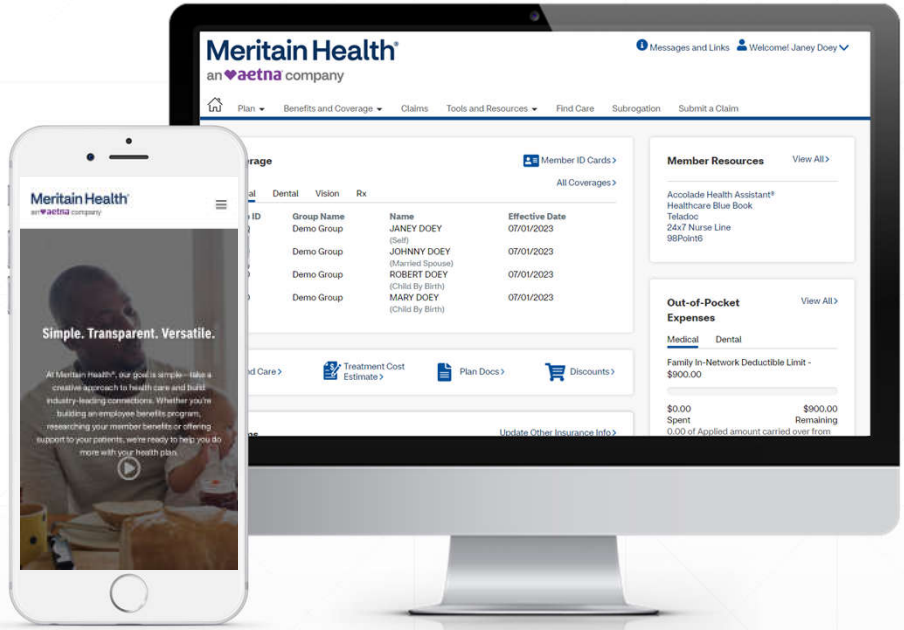
Medical Claim Submission

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.

frontpath HEALTH COALITION ®

Meritain.com



You can access the website by computer, tablet or via the Meritain Health mobile app on your iPhone® or Android™.

From the website you can:

- Find the status of a claim
- View claims history
- Print Explanations of Benefits (EOBs)
- See Plan documents
- View eligibility details
- Search wellness resources
- Access ID cards (view, print or request new cards)
- Request a Letter of Coverage

Explanation of Benefits (EOB)

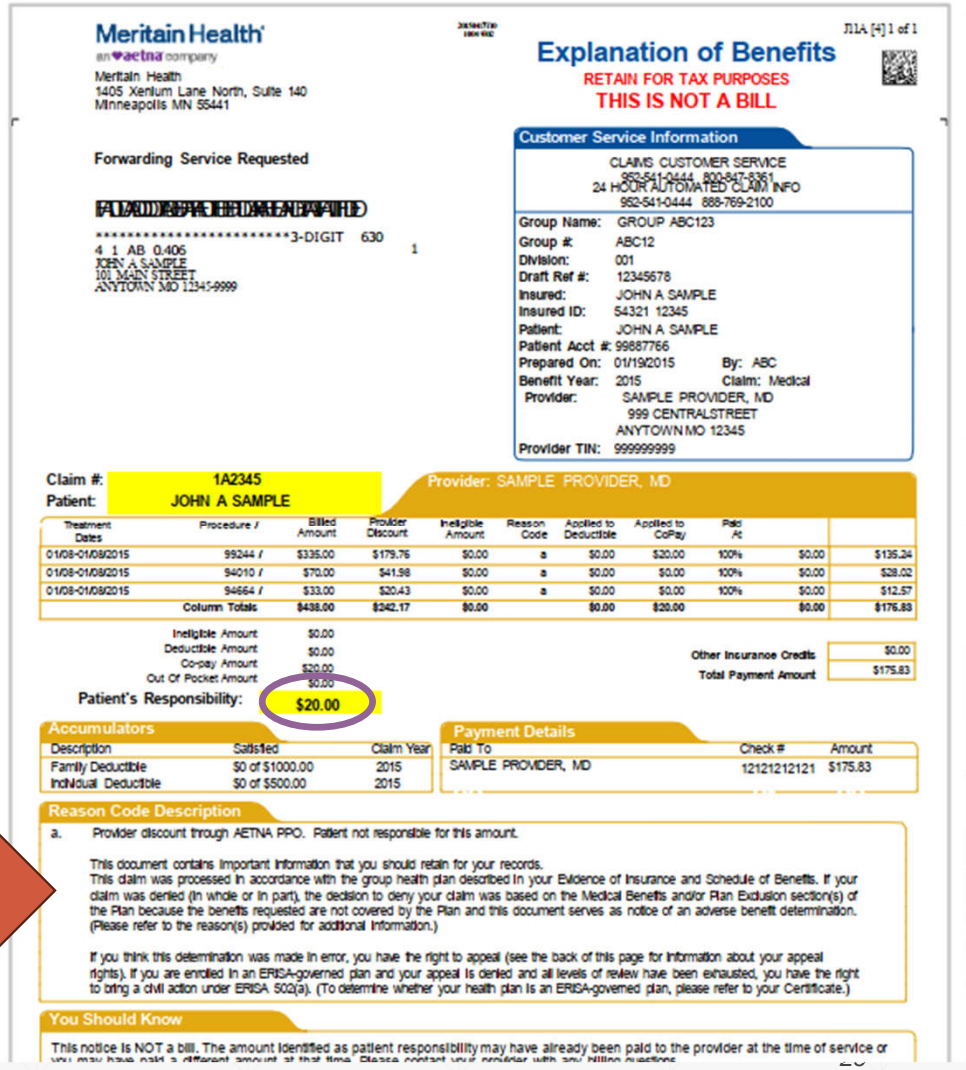
IMPORTANT: REVIEW THIS DOCUMENT UPON RECEIPT

This notice may state that a claim was denied and that additional information is needed.

Common reasons for claim denial:

- Provider is not submitting the claim sent to incorrect address.
- Provider did not provide primary insurance information needed for Coordination of Benefits with claim submission.
- Subrogation Questionnaire needs completed by the employee.
- Provider submitted claim after filing deadline.
- Provider did not precertify services.
- Letter of Medical Necessity needed from Provider.

Follow-up with your provider is recommended to resubmit claim.



Meritain Health
an aetna company
Meritain Health
1405 Xenium Lane North, Suite 140
Minneapolis MN 55441

Forwarding Service Requested

[redacted]
*****3-DIGIT 630
4 1 AB 0.406
JOHN A SAMPLE
101 MAIN STREET
ANYTOWN MO 12345-9999

J1A [4] 1 of 1

Explanation of Benefits
RETAIN FOR TAX PURPOSES
THIS IS NOT A BILL

Customer Service Information
CLAIMS CUSTOMER SERVICE
952-541-0444 800-847-9361
24 HOUR AUTOMATED CLAIM INFO
952-541-0444 888-769-2100

Group Name: GROUP ABC123
Group #: ABC12
Division: 001
Draft Ref #: 12345678
Insured: JOHN A SAMPLE
Insured ID: 54321 12345
Patient: JOHN A SAMPLE
Patient Acct #: 99887766
Prepared On: 01/19/2015 By: ABC
Benefit Year: 2015 Claim: Medical
Provider: SAMPLE PROVIDER, MD
999 CENTRALSTREET
ANYTOWN MO 12345
Provider TIN: 999999999

Claim #: 1A2345
Patient: JOHN A SAMPLE
Provider: SAMPLE PROVIDER, MD

Treatment Dates	Procedure /	Billed Amount	Provider Discount	Ineligible Amount	Reason Code	Applied to Deductible	Applied to CoPay	Paid At	
01/08-01/08/2015	99244 /	$335.00	$179.76	$0.00	a	$0.00	$20.00	100%	$0.00 $135.24
01/08-01/08/2015	94010 /	$70.00	$41.98	$0.00	a	$0.00	$0.00	100%	$0.00 $28.02
01/08-01/08/2015	94664 /	$33.00	$20.43	$0.00	a	$0.00	$0.00	100%	$0.00 $12.57
	Column Totals	$438.00	$242.17	$0.00		$0.00	$20.00		$0.00 $176.83

Ineligible Amount $0.00
Deductible Amount $0.00
Co-pay Amount $20.00
Out Of Pocket Amount $0.00
Patient's Responsibility: $20.00

Other Insurance Credits $0.00
Total Payment Amount $175.83

Accumulators

Description	Satisfied	Claim Year
Family Deductible	$0 of $1000.00	2015
Individual Deductible	$0 of $500.00	2015

Payment Details

Paid To	Check #	Amount
SAMPLE PROVIDER, MD	12121212121	$175.83

Reason Code Description

a. Provider discount through AETNA PPO. Patient not responsible for this amount.

This document contains important information that you should retain for your records.
This claim was processed in accordance with the group health plan described in your Evidence of Insurance and Schedule of Benefits. If your claim was denied (in whole or in part), the decision to deny your claim was based on the Medical Benefits and/or Plan Exclusion section(s) of the Plan because the benefits requested are not covered by the Plan and this document serves as notice of an adverse benefit determination. (Please refer to the reason(s) provided for additional information.)

If you think this determination was made in error, you have the right to appeal (see the back of this page for information about your appeal rights). If you are enrolled in an ERISA-governed plan and your appeal is denied and all levels of review have been exhausted, you have the right to bring a civil action under ERISA 502(a). (To determine whether your health plan is an ERISA-governed plan, please refer to your Certificate.)

You Should Know

This notice is NOT a bill. The amount identified as patient responsibility may have already been paid to the provider at the time of service or

Chronic Condition Management: Teladoc

Teladoc Health program offers a personalized experience to help members understand their condition and develop healthy lifestyle habits.

- Must have one of the following qualifying conditions:
- Diabetes – diagnosed Type 1 or Type 2
- Prediabetes – meets CDC National Diabetes Prevention Program qualification criteria
- Hypertension

Know where to go…

Need a primary care physician?

Wood County Health Department
Community Health Center

- Taking new patients
- Offers Sliding Fee Schedule even for those with insurance coverage
- Provides access to the Rx Savings Program

Acute Issues/Monitoring

PRIMARY CARE PHYSICIAN

Need urgent care?

FALCON
HEALTH CENTER

- Bills at the doctor office rate, which is lower than an urgent care facility

After Hours/Non-Life Threatening

URGENT CARE

Life Threatening/Medical Emergency

EMERGENCY ROOM

Non-emergency visit may not be covered by the Plan.

PRESCRIPTION COVERAGE

Formulary	Retail Pharmacy Copay 34-day supply Maximum	Mail Order Copay 90-day supply Maximum	RX Savings Program Copay 90-day supply
Tier 1 or select OTC with prescription	$5	$10	**$5**
Tier 2	$20 + 20% TCC; **$45 max**	$40 + 20% TCC; **$90 max**	
Tier 3	$20 + 20% TCC; **$85 max**	$40 + 20% TCC; **$170 max**	
Medical Necessity Review	$20 + 50% TCC; **$200 max**	$20 + 50% TCC; **$400 max**	Some restrictions apply. See Page 14 of the Health Benefits Guide for more information

TCC (Total Claim Charge) = Drug Ingredient Cost plus Dispensing Fee

Prescriptions can move between tiers & may be removed from the formulary throughout the year

RX Savings Program: Savings Example for Eliquis 4 mg tablet – Tier II

Retail Pharmacy

- $45 per month (30-day fill)
- $540 annually

Mail Order

- Not Available >$1,000 Limited to Retail or Rx Savings Program

Rx Savings Program

- $5 for 90-day supply*
- $20 annually

* Some restrictions apply

Any prescription over $1,000 is limited to a 30-day fill.
Not all medications are available under this program.

You save up to $520 annually

Wood County Health Department
Community Health Center

Wood County Health Department
Community Health Center

- A federally qualified health center, the Community Health Center provides comprehensive primary and preventive care.
- Located at 1840 East Gypsy Lane, it is an entity of the Wood County Health Department.

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.

Pharmacy staff take lunch from Noon - 1 p.m. Monday through Thursday.

Call 419.354.9049 to schedule an appointment.

Benefit Preservation Program

- Utilizes Patient Assistance Programs and/or Copay Assistance Coupons for eligible members.
- MedBenRx will reach out directly to the member to see if they qualify and offer assistance in enrollment in available programs.

1-877-393-0009
help@benefitspreservationprogram.com

MedBen Rx pharmacy solutions

Change my Preferences

Logout

Eligibility Listing | Group | My Plan | Rx Claims | Accumulators | Email/Phone Change | Requests | Contact Us

Message Center

Welcome

Participant Name:
Address:
Birth Date:

What would you like to do today?

- View Coverage Information
- Locate A Nearby Pharmacy
- View Rx History
- View Out-of-Pocket & Deductible Accumulators
- Compare Drug Pricing
- View My ID Card

mbaccess.medben.com

DENTAL COVERAGE

Not subject to deductible.

Dental Benefits - Delta Dental

Class I: Covered annually at 100% of the Usual, Customary and Reasonable (UCR) fee. Not subject to the deductible -- includes 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:

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

Useful Tip: Predetermination of benefits is recommended for services over $200

Dual PPO Network Model—Overview

Delta Dental PPO™	Delta Dental Premier®

- Delta Dental PPO™
  - The deepest discounted PPO network
- Delta Dental Premier®
  - A broad-access PPO network with significant discounts
- Access to the nation's largest dental network
  - We combine our two PPO networks to drive superior value
  - Deep discounts for all patients visiting a Delta Dental in-network provider
  - Claims are adjudicated in a manner to maximize savings

Stay in network and save!

Visiting an in-network dentist will likely save you the most money

All Delta Dental participating dentists agree to accept lower fees as full payment for covered services. They also agree to abide by our processing policies and will submit claims for you.

Savings example for a crown by network: Delta Dental PPO (Point-of-Service)

Submitted charge: $1,100 (covered at 50% coinsurance)

Network	Delta Dental PPO	Delta Dental Premier®	Out-of-network
Savings level	**Most significant savings**	**Significant savings**	**No savings**
Dentist's agreed upon fee	$754	$988	$1,100
Amount Delta Dental pays	$377	$494	$399
Amount you pay	**$377**	**$494**	**$701**
Amount you save	$346	$112	$0

No balance billing

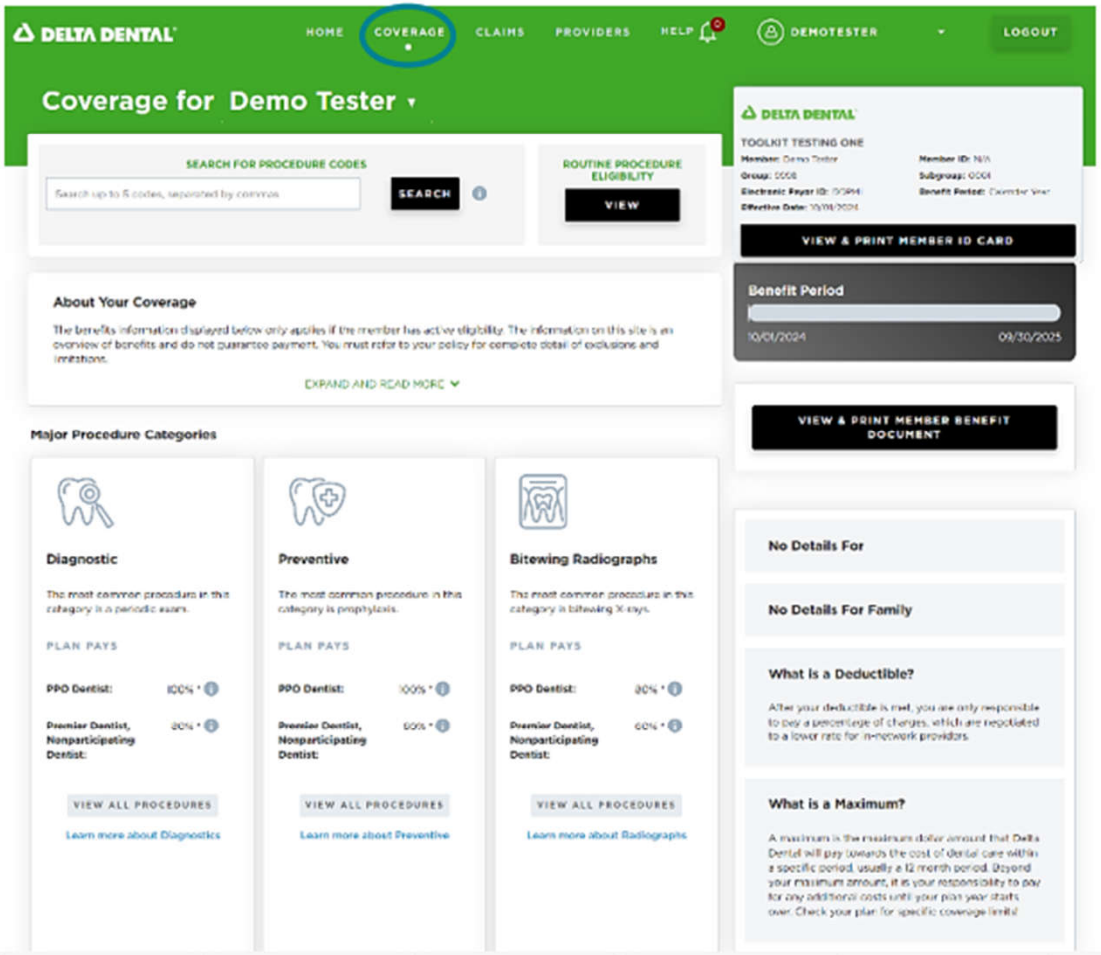
Dentist can balance bill up to **submitted charge**

NOTE: Payment example above is illustrative only. Fees and reimbursements can vary by location and dentist.

Member Portal Features

Find your benefits

Confirm eligibility and review benefits by clicking the **Coverage** link at the top.



Vision Benefit

Vision Program

Payable only as primary (no coordination of benefits)

No restriction on access

Requires original receipt and claim form with patient and services clearly identified

Covers

Exams

Prescription glasses/ frames and contacts

Refractive Surgery

Benefit Period

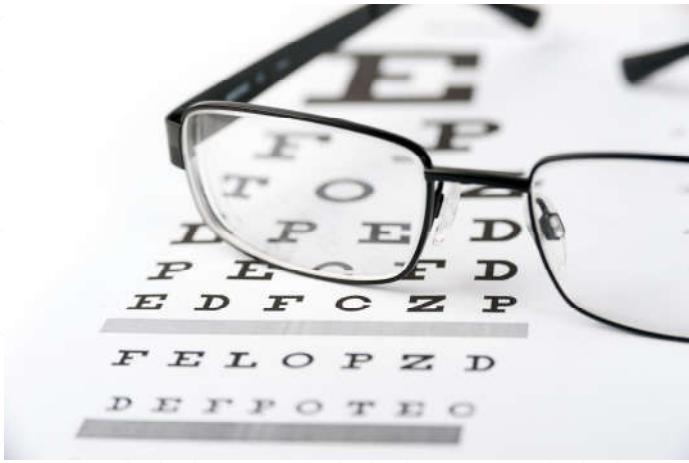
Up to $150 available per participant

Automatic carryover of unused benefit into next benefit period

(2025 to 2026; 2026 to 2027)

Submit 2026 claims by March 31, 2027.

Vision Coverage



Provide detailed receipts with claim form. Must include:

- Patient Name
- Date of Service
- Proof of Payment (a credit card summary or WalMart cash register receipt is not sufficient on its own)
- Itemized List of Goods/Service (a copy of the prescription may be required to confirm who received services)

Life Insurance Benefit – Mandatory Enrollment

Term Insurance - Certificate available on Employee Website

- $20,000 Policy*

Benefits Terminate at Separation of Employment

- Conversion Opportunities

Accelerated Death Benefit

Waiver of Premium

Wellness Screening Required – Results not shared with Employer

*Board of DD Employees Refer to the Life Certificate for Board of DD

Enrolling & Waiving Coverage

Monthly Premiums ● Universal Application to enroll or waive coverage

Single Coverage	Total Rate	Employer	Employee	COBRA
Health & 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	Total Rate	Employer	Employee	COBRA
Health & 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*	$8.54	$8.54	$0	N/A
Total	$2,482.86	$2,111.72	$371.14	

*Board of DD Employees refer to the Life Certificate

2026 Monthly Premiums

- 85% - Paid by Employer
- 15% - Paid by Employee

- Premium is split between the first and second pay dates of each month.
- May be collected on a pre-tax basis under the Section 125 Premium Only Plan (POP).

Insufficient Wages for Monthly Payroll Deductions

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 payroll deductions, your payroll deduction will stop.

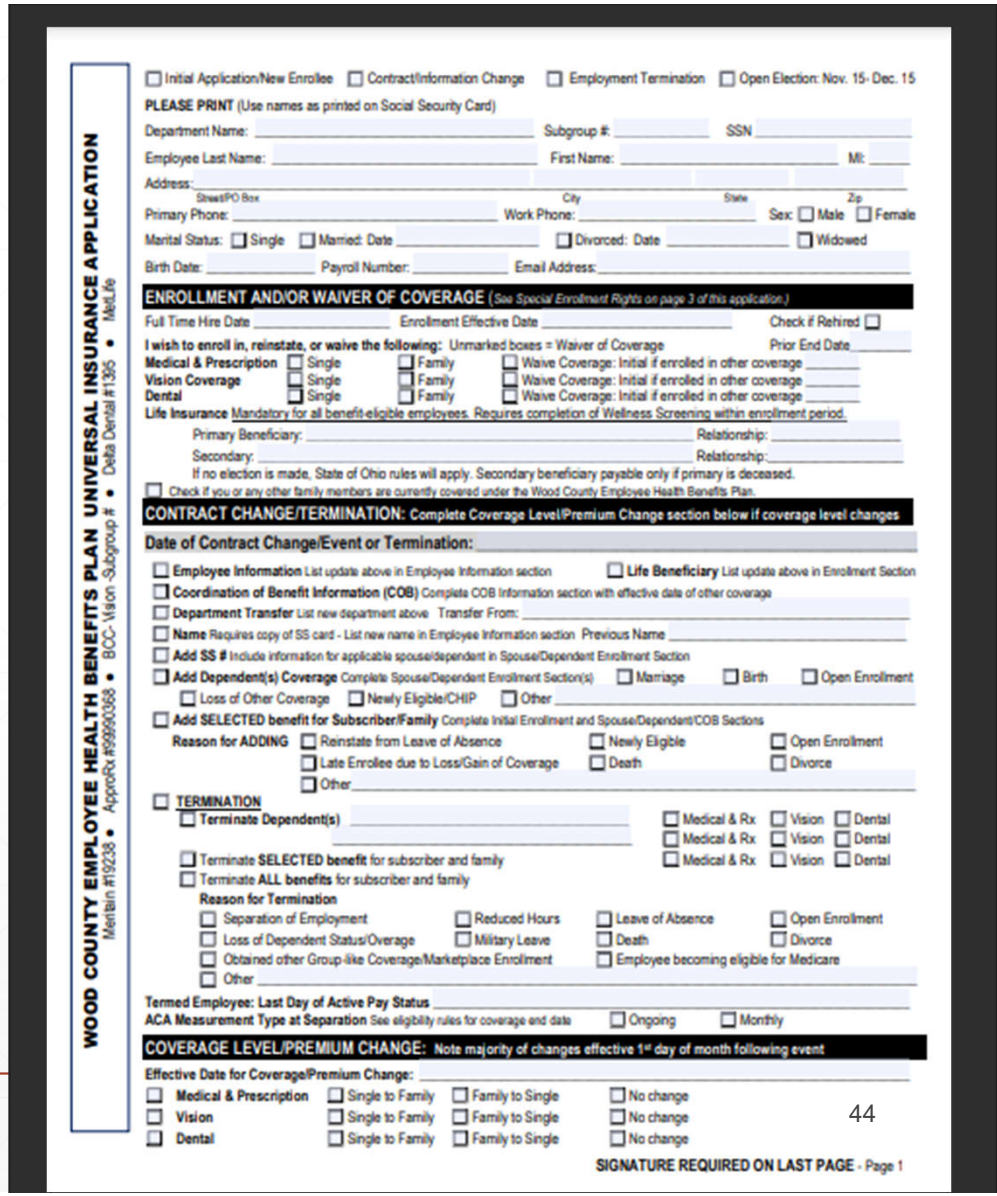
You will be required to self-pay the full employee portion of the monthly premium by the last day of the month prior to the month of coverage. A five working days advance notice is required if you choose to continue coverage.

Failure 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.

Enrollment

- During the **30-day waiting period** (enrollment period), benefit eligible employees must elect or waive coverage by submitting a Universal Application along with any required certification forms.
- Completion of a confidential Wellness Screening is also **required** prior to enrollment for employees and their spouse's seeking coverage. Individuals who **fail to complete the stated requirements will not be eligible for coverage until the next Open Election Period.**
- A Special Enrollment Right permits enrollment within 30 days of a Qualifying Event for those who initially waived coverage (see Page 2 of the Health Benefits Guide).
- Also note that the IRS restricts enrollment in other coverage if enrolled in a High Deductible Plan that is partnered with a Health Savings Account (HSA).
- Use names listed on your/dependents social security cards



WOOD COUNTY EMPLOYEE HEALTH BENEFITS PLAN UNIVERSAL INSURANCE APPLICATION

MetLife • Delta Dental #1395 • BCC Vision -Subgroup # • ApproRx #99990068 • MetBank #19238

☐ Initial Application/New Enrollee ☐ Contract/Information Change ☐ Employment Termination ☐ Open Election: Nov. 15- Dec. 15

PLEASE PRINT (Use names as printed on Social Security Card)

Department Name: _____ Subgroup #: _____ SSN _____

Employee Last Name: _____ First Name: _____ MI: ____

Address: _____ (Street/PO Box / City / State / Zip)

Primary Phone: _____ Work Phone: _____ Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married: Date _____ ☐ Divorced: Date _____ ☐ Widowed

Birth Date: _____ Payroll Number: _____ Email Address: _____

ENROLLMENT AND/OR WAIVER OF COVERAGE (*See Special Enrollment Rights on page 3 of this application.*)

Full Time Hire Date _____ Enrollment Effective Date _____ Check if Rehired ☐

I wish to enroll in, reinstate, or waive the following: Unmarked boxes = Waiver of Coverage Prior End Date _____

Medical & Prescription ☐ Single ☐ Family ☐ Waive Coverage: Initial if enrolled in other coverage _____

Vision Coverage ☐ Single ☐ Family ☐ Waive Coverage: Initial if enrolled in other coverage _____

Dental ☐ Single ☐ Family ☐ Waive Coverage: Initial if enrolled in other coverage _____

Life Insurance Mandatory for all benefit-eligible employees. Requires completion of Wellness Screening within enrollment period.

Primary Beneficiary: _____ Relationship: _____

Secondary: _____ Relationship: _____

If no election is made, State of Ohio rules will apply. Secondary beneficiary payable only if primary is deceased.

☐ Check if you or any other family members are currently covered under the Wood County Employee Health Benefits Plan.

CONTRACT CHANGE/TERMINATION: Complete Coverage Level/Premium Change section below if coverage level changes

Date of Contract Change/Event or Termination: _____

☐ **Employee Information** List update above in Employee Information section ☐ **Life Beneficiary** List update above in Enrollment Section

☐ **Coordination of Benefit Information (COB)** Complete COB Information section with effective date of other coverage

☐ **Department Transfer** List new department above Transfer From: _____

☐ **Name** Requires copy of SS card - List new name in Employee Information section Previous Name _____

☐ **Add SS #** Include information for applicable spouse/dependent in Spouse/Dependent Enrollment Section

☐ **Add Dependent(s) Coverage** Complete Spouse/Dependent Enrollment Section(s) ☐ Marriage ☐ Birth ☐ Open Enrollment

☐ Loss of Other Coverage ☐ Newly Eligible/CHIP ☐ Other _____

☐ **Add SELECTED benefit for Subscriber/Family** Complete Initial Enrollment and Spouse/Dependent/COB Sections

Reason for ADDING ☐ Reinstate from Leave of Absence ☐ Newly Eligible ☐ Open Enrollment

☐ Late Enrollee due to Loss/Gain of Coverage ☐ Death ☐ Divorce

☐ Other _____

☐ **TERMINATION**

☐ **Terminate Dependent(s)** _____ ☐ Medical & Rx ☐ Vision ☐ Dental

☐ Medical & Rx ☐ Vision ☐ Dental

☐ Medical & Rx ☐ Vision ☐ Dental

☐ Terminate **SELECTED benefit** for subscriber and family

☐ Terminate **ALL benefits** for subscriber and family

Reason for Termination

☐ Separation of Employment ☐ Reduced Hours ☐ Leave of Absence ☐ Open Enrollment

☐ Loss of Dependent Status/Overage ☐ Military Leave ☐ Death ☐ Divorce

☐ Obtained other Group-like Coverage/Marketplace Enrollment ☐ Employee becoming eligible for Medicare

☐ Other _____

Termed Employee: Last Day of Active Pay Status _____

ACA Measurement Type at Separation See eligibility rules for coverage end date ☐ Ongoing ☐ Monthly

COVERAGE LEVEL/PREMIUM CHANGE: Note majority of changes effective 1st day of month following event

Effective Date for Coverage/Premium Change: _____

☐ **Medical & Prescription**	☐ Single to Family	☐ Family to Single	☐ No change
☐ **Vision**	☐ Single to Family	☐ Family to Single	☐ No change
☐ **Dental**	☐ Single to Family	☐ Family to Single	☐ No change

SIGNATURE REQUIRED ON LAST PAGE - Page 1

2023 Eligibility Guide for the Wood County Employee Health Benefits Plan

Coverage/Process	Eligibility Details - Review SPD for full details	Type of Coverage H & P	V	D	L	Report Timeframe	Effective Date	Forms Required within 30 days of QE - Universal Application (UA) required for all contract changes
Full-time ACA	- 30 hours per week or more - Measured monthly until the end of stability period	H & P	V	D	L	w/i first 30 days	FDM following 30 days eligibility	- Spouse + Dependent certification if applicable - Confidential Wellness Screening for Employee & Spouse (primary or secondary): Required w/i 30 days - Benefit Eligible Checklist: All Boxes/Lines Completed + Signed - Wellness Waiver
Part-time: Reasonably expected not to be Full-time (Variable Hour or Seasonal)	- Delayed Offer - Not Full-time ACA at time of hire. - Eligibility determined following the completion of 26 full pay periods. - Works less than 30 hours per week	H & P	V	D	L	IMP = 12 months to measure average hours worked per week.	See Other Info	- Non Benefit Eligible Insurance Checklist - IMP & Admin period can't extend beyond 13 months from hire date plus number of days from the hire date to month-end.
Seasonal: Six months or less per year, same employment time each year.	- Delayed Offer - Break in service of 13 weeks between seasonal work - not expected to be Full Time	H & P	V	D	L			- Non Benefit Eligible Insurance Checklist
Enrollee Continued Eligibility	Monthly: 130 hours of service per mo. Standard: one hour of service per mo.	H & P	V	D	L		FDM in which loss eligibility	Loss of eligibility = termination of benefits. COBRA offered. May self-pay full premium if approved leave w/o pay non-FMLA, 5 day notification prior to month of coverage is provided
Spouse as Primary Lawful spouse- based on spouse's annual adjusted gross income	- Tier 1: Less than $33,500 - Tier 2: $33,500 to $63,200 - Tier 3: Greater than $63,200 Spousal Premium applies for tier 2, tier 3 spouse not eligible for coverage	H & P	V	D		w/i 30 days of event Submit paperwork as soon as you get it	Date of Marriage FDM following QE	- Spouse Wellness Screening: Required for all benefits - Spousal Certification Process: Full Tax Return + Certification Forms Required - Spousal Income Verification
Spouse as Secondary	- Lawful spouse - DOL prohibits COB w/ HDP + HSA - No Secondary Vision	H & P		D		w/i 30 days of event	FDM following QE	- Primary Coverage Information - Wellness Screening (for any type of coverage)
Spouse/Dependent eligible for Medicare	- Spouses 65 or older - Spouses/Dependents disabled	H & P				w/i 30 days of event	Date enrolled in Medicare	- OBRA form - Review for Primary/Secondary details. * If Plan is selected as primary, Medicare becomes secondary. * If Medicare is selected primary, Plan terms FDM following
Dependent - Birth to 26 (Federal Requirement).	- Eligible until the end of the month in which dependent turns 26. * If disabled, check SPD for details	H & P				w/i 30 days of event or 60 days depending on event	- Date of birth - FDM following QE date of birth or adoption date	- Adoption Documentation (if applicable) - Medicaid/CHIP (if applicable) - QMCSO (birth to 18) (if applicable) - OBRA Form if child is disabled (if applicable)
Dependent - 26th Birthdate	aged out - no longer eligible	H & P					FDM following birthdate	- COBRA Personnel Action Form
Dependent - birth to 19 - Review SPD for eligibility details	- Eligible until the end of the year in which dependent turns 19 - QMCSO or Disabled		V	D		w/i 30 days of event w/i 60 days of event	- Date of birth - Marriage - FDM Following QE	- QMCSO = FDM following receipt
Dependent - 19 to 23 (Jan 1 following 19th birthday through end of calendar year in which turn 23)	- FT Student/Meets Eligibility Rules - Must continue FT between semesters/quarters and go back FT		V	D		w/i 30 days of event	FDM Following QE	- Dependent Certification - Must meet ALL Eligibility Rules - FT Student to PT Student, Graduation, or Resign from College = Report Immediately
Dependent as Secondary	- No Secondary Vision	H & P		D		w/i 30 days of event	FDM following QE	- UA with primary coverage information
Birth to 19	- No Secondary Vision	H & P		D		w/i 30 days of event	FDM following QE	- UA with primary coverage information
19 to 23	- No Secondary Vision	H & P		D		w/i 30 days of event	FDM following QE	- UA with primary coverage information - Dependent Certification
23 to 26	- No Secondary Vision	H & P				w/i 30 days of event	FDM following QE	- UA with primary coverage information
Disabled Dependent	Meets eligibility rules. Must be declared prior to reaching limiting age, check plan document for details	H & P	V	D		w/i 60 days of enrollment or following limiting age		- Court Order and Social Security Disability Determination

Eligibility Guide

Helps identify needed forms, effective dates, and other information regarding eligibility.

Complete a Wellness Screening

- Mandatory – Complete within your 30-day enrollment period
- Required for all new employees prior to enrollment in the Plan and for their spouses if enrolling in the Plan as primary or secondary

Health Risk Assessment

Coronary Risk (HDL/LDL)

Blood Pressure

Bone Density

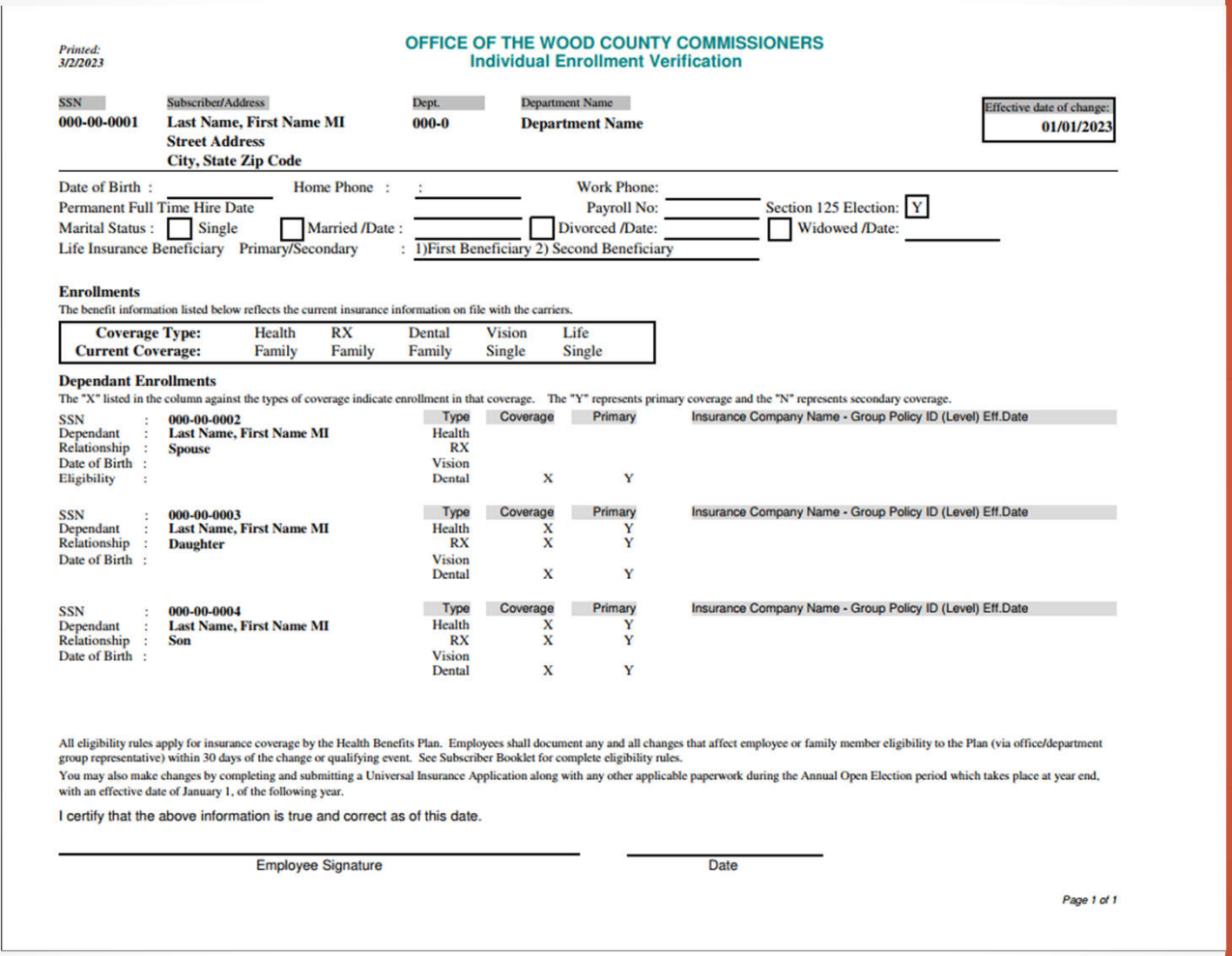
A1C (Blood Sugar)

Occult Blood Screening

FREE & 100% CONFIDENTIAL – ONLY RECEIVING THE DATE COMPLETED

Wood County Hospital
Depend on us.

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.



Printed:
3/2/2023

OFFICE OF THE WOOD COUNTY COMMISSIONERS
Individual Enrollment Verification

SSN	Subscriber/Address	Dept.	Department Name	Effective date of change:
000-00-0001	Last Name, First Name MI Street Address City, State Zip Code	000-0	Department Name	01/01/2023

Date of Birth : _____ Home Phone : : _____ Work Phone: _____
Permanent Full Time Hire Date _____ Payroll No: _____ Section 125 Election: Y
Marital Status : ☐ Single ☐ Married /Date : _____ ☐ Divorced /Date: _____ ☐ Widowed /Date: _____
Life Insurance Beneficiary Primary/Secondary : 1)First Beneficiary 2) Second Beneficiary

Enrollments

The benefit information listed below reflects the current insurance information on file with the carriers.

Coverage Type:	Health	RX	Dental	Vision	Life
Current Coverage:	Family	Family	Family	Single	Single

Dependant Enrollments

The "X" listed in the column against the types of coverage indicate enrollment in that coverage. The "Y" represents primary coverage and the "N" represents secondary coverage.

		Type	Coverage	Primary	Insurance Company Name - Group Policy ID (Level) Eff.Date
SSN :	000-00-0002	Health			
Dependant :	Last Name, First Name MI	RX			
Relationship :	Spouse	Vision			
Date of Birth :		Dental	X	Y	
Eligibility :					
SSN :	000-00-0003	Type	Coverage	Primary	Insurance Company Name - Group Policy ID (Level) Eff.Date
Dependant :	Last Name, First Name MI	Health	X	Y	
Relationship :	Daughter	RX	X	Y	
Date of Birth :		Vision			
		Dental	X	Y	
SSN :	000-00-0004	Type	Coverage	Primary	Insurance Company Name - Group Policy ID (Level) Eff.Date
Dependant :	Last Name, First Name MI	Health	X	Y	
Relationship :	Son	RX	X	Y	
Date of Birth :		Vision			
		Dental	X	Y	

All eligibility rules apply for insurance coverage by the Health Benefits Plan. Employees shall document any and all changes that affect employee or family member eligibility to the Plan (via office/department group representative) within 30 days of the change or qualifying event. See Subscriber Booklet for complete eligibility rules.

You may also make changes by completing and submitting a Universal Insurance Application along with any other applicable paperwork during the Annual Open Election period which takes place at year end, with an effective date of January 1, of the following year.

I certify that the above information is true and correct as of this date.

_____ _____
Employee Signature Date

Page 1 of 1

Individual Enrollment Verification Form (IEV)

- Sent following receipt of Universal Application.
- Review upon receipt and acknowledge information provided is accurate with signoff.

Identification Cards

- Approx. 30 days to receive.
- Register for Vendor Portal for access to digital copies.
- Vendor and Group Numbers needed are listed on the back of the Health Benefits Guide.
- If services are needed prior to activation in the vendor's system:
  - Medical - Interim medical services use SS#
    - Once ID Card is available on vendor portal, request the provider resubmit claim.
  - Prescription – Purchase & Request reimbursement
    - A paper claim form is available on the employee website to request reimbursement. Reimbursement may take up to 45 days.

COBRA Notification

- 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.
- See page 6 of the Health Benefits Guide

Special Enrollment Rights

Qualifying Events/Reporting Requirement

Special Enrollment Rights

- If you are declining enrollment for yourself or your dependents (including your spouse) because of enrollment in other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends.
- You may be able to enroll yourself and your eligible dependents if you have a Qualifying Event (e.g., marriage, birth, adoption or placement for adoption, death, change of employment status that results in a gain or loss of insurance eligibility, etc.).
- Changes must be reported within 30 days of the Qualifying Event.
  - Examples: Address, adding dependents, loss of eligibility

Understand Your Plan's Rules

Report Other Insurance Coverage

- Coordination of Benefits
  - Contract Holder is Primary on their coverage, secondary on other coverage
  - Children use birthday rule if dual coverage
  - High Deductible with HSA (possible limitations – contact your tax advisor)

Report Changes within 30 days of Event

- Special Enrollment Opportunities/Qualifying Events see page 9 of the Health Benefits Guide

Open Election Period (Nov. 15 – Dec. 15)

- Benefit eligible employees are automatically re-enrolled in their existing coverage for the following calendar year.
- Every year during the Open Election period, eligible employees have the opportunity to enroll in, or make changes to, their benefit program **without a Special Enrollment Right.**
- To request a change to your coverage during Open Election, employees must submit a completed Universal Application with any required certification forms to their Insurance Group Representative by December 15.
- Permitted changes become effective January 1 of the next year.

Wellness Programs

Every Minute Counts

Earn Deductible Credit

for your 2027 Medical Deductible

• 5,000 active minutes	$25
• 6,500 active minutes	$50
• 8,000 active minutes	$75
• 9,500 active minutes	$100

Refer to the Health Benefits Guide for Available Wellness Programs

Every Minute Counts!

Wellness Screenings

- Required for enrollment
- Available annually thereafter
- Know Your Numbers
  HDL/LDL/A1C/Optional PSA
- Lower cost option for lab work
- Take results to your physician

Provides Access to Reimbursement for On-Line Fitness & Nutrition Programs

- Program purchase must be made within the same year
- Up to $50 reimbursement available

Receive 60 minutes of Wellness Credit Overtime for completing your screening in 2026!

Reimbursement Programs

- **Fitness Facility**
- **Open Swim**
- **Tobacco Termination**

Reimbursement forms and deadlines are posted on the Employee Website under the Wellness Programs.

Programs are a taxable fringe benefit.

Ohio Tobacco Quit Line

Counseling to help you quit smoking and/or the use of other tobacco products, including electronic cigarettes.

Available 24 hours a day, 7 days a week.

Your choice of nicotine patches, gum or lozenges sent directly to your home.

And it's all free. For everyone in Ohio.

Call 1-800-QUIT NOW (1-800-784-8669) to start your journey to a nicotine-free life, today.

There are so many reasons to quit.

What's yours?

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

Federal Notices

Attachment B

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149

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.*

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: **Benefit Clerk, Wood County Commissioners' Office at 419.354.9100 or jschroeder@woodcountyohio.gov or swilliams@woodcountyohio.gov.**

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

PART B: Information About Health Coverage Offered by Your Employer

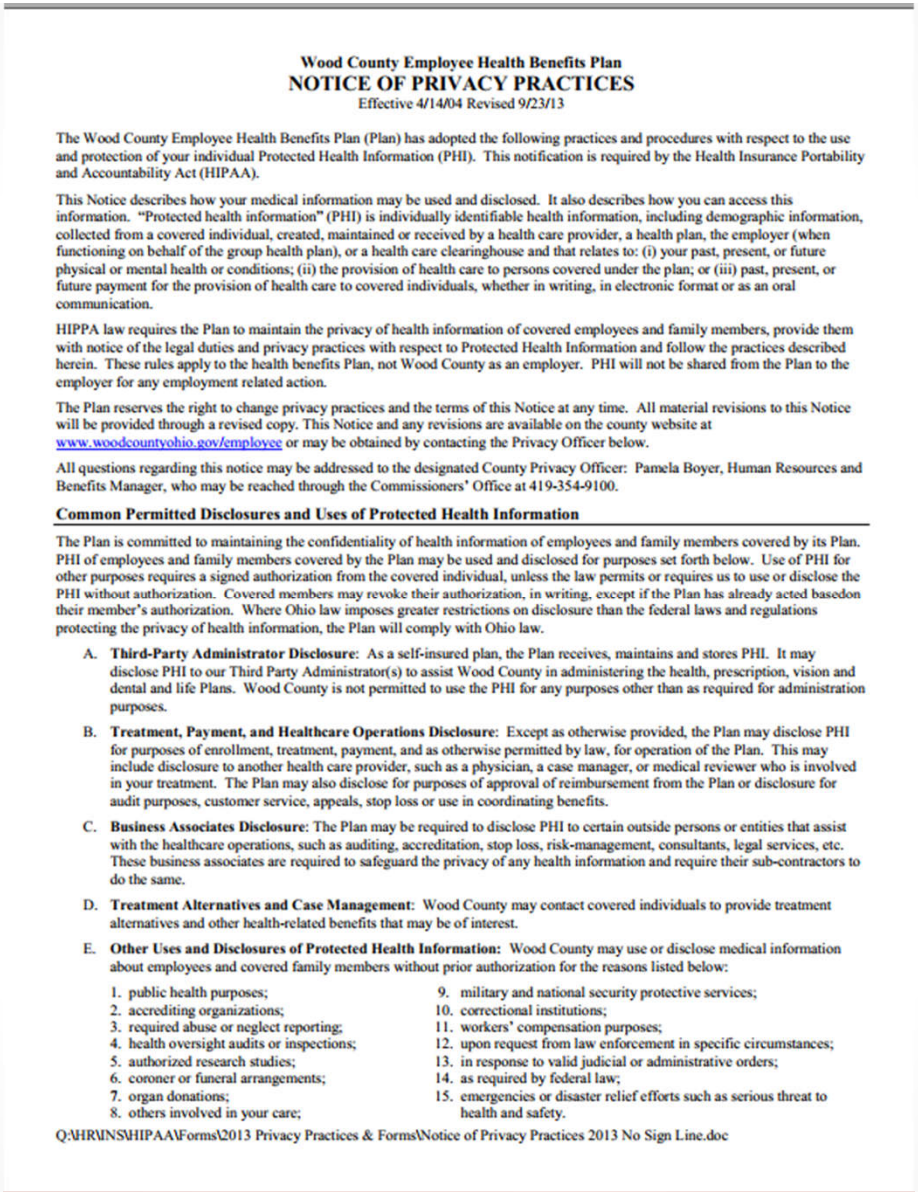
This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer Name		4.Employer Identification Number (EIN)
Wood County, Ohio		34-6401607
5. Employer Address		6. Employer Phone Number
One Courthouse Square		419-354-9100
7. City	8. State	9. Zip Code
Bowling Green	Ohio	43402
10. Who can we contact about health coverage at this job?		
Josh Schroeder or Shelby Williams, Benefits Clerk		
11. Phone Number (if different from above)		12. Email Address
Same		jschroeder@woodcountyohio.gov or swilliams@woodcountyohio.gov

C/HR/Ins/health Care Reform/Marketplace Notices * 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 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Marketplace Notice

- Gives information about where to find other coverage.



Wood County Employee Health Benefits Plan

NOTICE OF PRIVACY PRACTICES

Effective 4/14/04 Revised 9/23/13

The Wood County Employee Health Benefits Plan (Plan) has adopted the following practices and procedures with respect to the use and protection of your individual Protected Health Information (PHI). This notification is required by the Health Insurance Portability and Accountability Act (HIPAA).

This Notice describes how your medical information may be used and disclosed. It also describes how you can access this information. "Protected health information" (PHI) is individually identifiable health information, including demographic information, collected from a covered individual, created, maintained or received by a health care provider, a health plan, the employer (when functioning on behalf of the group health plan), or a health care clearinghouse and that relates to: (i) your past, present, or future physical or mental health or conditions; (ii) the provision of health care to persons covered under the plan; or (iii) past, present, or future payment for the provision of health care to covered individuals, whether in writing, in electronic format or as an oral communication.

HIPPA law requires the Plan to maintain the privacy of health information of covered employees and family members, provide them with notice of the legal duties and privacy practices with respect to Protected Health Information and follow the practices described herein. These rules apply to the health benefits Plan, not Wood County as an employer. PHI will not be shared from the Plan to the employer for any employment related action.

The Plan reserves the right to change privacy practices and the terms of this Notice at any time. All material revisions to this Notice will be provided through a revised copy. This Notice and any revisions are available on the county website at www.woodcountyohio.gov/employee or may be obtained by contacting the Privacy Officer below.

All questions regarding this notice may be addressed to the designated County Privacy Officer: Pamela Boyer, Human Resources and Benefits Manager, who may be reached through the Commissioners' Office at 419-354-9100.

Common Permitted Disclosures and Uses of Protected Health Information

The Plan is committed to maintaining the confidentiality of health information of employees and family members covered by its Plan. PHI of employees and family members covered by the Plan may be used and disclosed for purposes set forth below. Use of PHI for other purposes requires a signed authorization from the covered individual, unless the law permits or requires us to use or disclose the PHI without authorization. Covered members may revoke their authorization, in writing, except if the Plan has already acted basedon their member's authorization. Where Ohio law imposes greater restrictions on disclosure than the federal laws and regulations protecting the privacy of health information, the Plan will comply with Ohio law.

A. **Third-Party Administrator Disclosure**: As a self-insured plan, the Plan receives, maintains and stores PHI. It may disclose PHI to our Third Party Administrator(s) to assist Wood County in administering the health, prescription, vision and dental and life Plans. Wood County is not permitted to use the PHI for any purposes other than as required for administration purposes.

B. **Treatment, Payment, and Healthcare Operations Disclosure**: Except as otherwise provided, the Plan may disclose PHI for purposes of enrollment, treatment, payment, and as otherwise permitted by law, for operation of the Plan. This may include disclosure to another health care provider, such as a physician, a case manager, or medical reviewer who is involved in your treatment. The Plan may also disclose for purposes of approval of reimbursement from the Plan or disclosure for audit purposes, customer service, appeals, stop loss or use in coordinating benefits.

C. **Business Associates Disclosure**: The Plan may be required to disclose PHI to certain outside persons or entities that assist with the healthcare operations, such as auditing, accreditation, stop loss, risk-management, consultants, legal services, etc. These business associates are required to safeguard the privacy of any health information and require their sub-contractors to do the same.

D. **Treatment Alternatives and Case Management**: Wood County may contact covered individuals to provide treatment alternatives and other health-related benefits that may be of interest.

E. **Other Uses and Disclosures of Protected Health Information:** Wood County may use or disclose medical information about employees and covered family members without prior authorization for the reasons listed below:

1. public health purposes;
2. accrediting organizations;
3. required abuse or neglect reporting;
4. health oversight audits or inspections;
5. authorized research studies;
6. coroner or funeral arrangements;
7. organ donations;
8. others involved in your care;
9. military and national security protective services;
10. correctional institutions;
11. workers' compensation purposes;
12. upon request from law enforcement in specific circumstances;
13. in response to valid judicial or administrative orders;
14. as required by federal law;
15. emergencies or disaster relief efforts such as serious threat to health and safety.

Q:\HR\INS\HIPAA\Forms\2013 Privacy Practices & Forms\Notice of Privacy Practices 2013 No Sign Line.doc

Notice of Privacy Practice (HIPAA)

- Sign off required by carrier to permit access to HIPAA information of family member

Claim/Benefit Questions?

Refer to the last page of the Health Benefits Guide for current vendor information

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

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

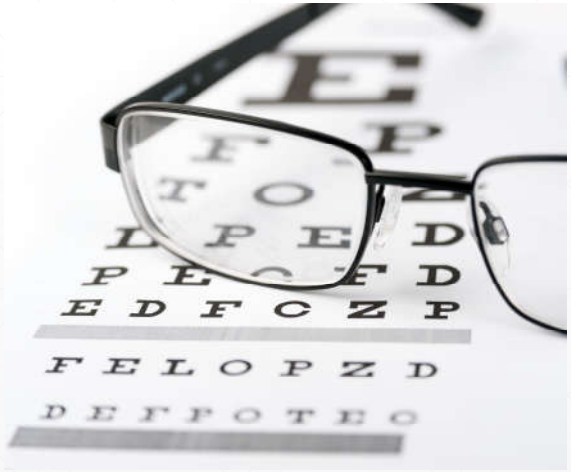
Group Number: 1395-1XXX

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



Eligibility Questions Contact

Benefits Line - 419.354.1373

benefits@woodcountyohio.gov
wellness@woodcountyohio.gov

Employee Website
www.woodcountyohio.gov

Employee Website: woodcountyohio.gov

Employee Website

One Courthouse Square Bowling Green, OH 43402 Phone: 419-354-9000 Toll Free: 1-866-860-4140 Email Us

Search...

Government Departments Quick Links How Do I...

- Medical Coverage
- Prescription Coverage
- Vision Coverage
- Dental Coverage
- Life Insurance Coverage

Home › How Do I... › Employee Website › Employee Health Benefits Plan

Employee Health Benefits Plan

The Commissioners are the trustees of the Health Benefits Plan and are committed to maintaining a quality, affordable health care plan for employees, although it is not a statutorily-mandated benefit. They believe this governmental, self-insured, non-ERISA Plan is a "grandfathered health plan" under the Federal Health Care Reform: Patient Protection and Affordable Health Care Act. As permitted by this Act, a grandfathered health plan can preserve basic health coverage that was already in effect when the law was enacted. 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.

Members of the Employees Health Benefits Committee take their role of preserving the long-term viability of employee benefits very seriously. Their task is difficult when weighing employee satisfaction and preservation of benefits.

Insurance Application and Forms

- Universal Application (PDF)
- Spousal Certification 2025
- Dependent Certification 2025
- OBRA Primary Coverage Selection Form (PDF)
- COBRA Personnel Action Report (PDF)

Notice to Employees:

Employers are no longer required to send employees a Form 1095-C, unless the employee requests a copy of the form, per the Paperwork Burden Reduction Act (H.R. 3797) ("PBRA"), passed by the 118th Congress on December 11, 2024.

Annual Insurance Meetings in November

- Provides an update on Plan performance and tips on how to utilize benefits in a more cost-effective manner.
- The complete meeting schedule noting locations and times can be viewed in the employee newsletter and on the employee website.
- A copy of the power point presentation will be posted on the employee website at www.woodcountyohio.gov following the meetings.