THE BOARD OF STARK COUNTY COMMISSIONERS EMPLOYEE HEALTH PLAN

Health Benefits 2025 Enrollment Guide

The Board of Stark County Commissioners Employee Health Benefits Plan

The County offers a comprehensive employee benefits plan designed to keep you and your family healthy and secure, while providing you with peace of mind.

Our benefits package includes one medical plan options, a prescription-drug plan, a Flexible Spending Account, a dental plan, a vision plan, group term life insurance (basic and supplemental), an Employee Assistance Program, plus voluntary benefits through Colonial!

In addition, you're eligible for state pension benefits, paid sick leave, holidays and other paid time off, plus you may enroll in a deferred compensation plan to increase your retirement savings.

We hope this benefits summary is a helpful tool as you make your benefit elections. Take time to review the information to choose the coverage that best fits your needs. If you have any questions about your benefits, contact the Benefits department at 330-451-7905 or email merichardson@starkcountyohio.gov.

Eligibility

If you're a County employee who's defined as "full-time" or "part-time-eligible", you may enroll in the benefits described in this guide.

Your family members are also eligible as your dependents for medical, prescription-drug, dental and vision coverage:

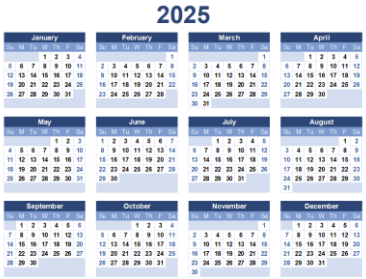
- Legal spouse
- Dependent children **under the age of 26**, regardless of other coverage available
- Dependent who's physically or mentally incapable of self-care

Note: Certain documents are required to confirm a dependent's eligibility and ensure proper coordination of benefits between your benefits plan and other individual or employer-sponsored health care coverage.

If your spouse or other dependents lose or obtain other health insurance, you must notify the Benefits Department within **31 days**. You're personally responsible for any benefits paid should you provide inaccurate information or fail to provide timely notification to the Benefits Department.

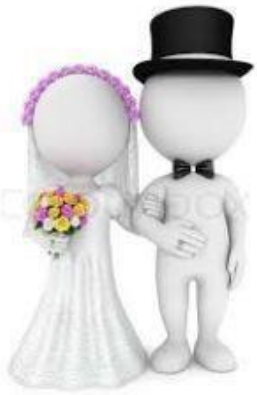
More information is available on the Employee Benefits Website: [Stark County Employee Benefits]

Enroll in Your Benefits



- During your new-hire orientation, or within 30 days from your date of hire.
- During Open Enrollment in November. The benefits you elect during Open Enrollment are effective January 1 of the following year.
- During the year, under a Special Enrollment Period, which is triggered by certain life-status changes (also referred to as "Change in Status" or "Qualifying Event").

Special Enrollment Period



Changes to your benefits and covered dependents can be made during Open Enrollment, or when you incur a life-status change, or qualifying event, which triggers a Special Enrollment Period.

Qualifying events include*:

- marriage/divorce/dissolution,
- birth/adoption of a child,
- death of spouse or other enrolled dependent,
- change in spouse's benefits or employment status,
- a dependent becomes eligible for Medicare/Medicaid,
- an adult dependent child becomes eligible for his or her own employer's benefits or other healthcare coverage

***Note:** There are more complicated situations that may qualify for a Special Enrollment Period. If in doubt, contact the Benefits Department at 330-451-7905.

If you want to make a benefits change due to one of these qualifying events during the plan year, contact the Benefits Department, complete an Application/Change/Waiver Form, and submit supporting documents. The effective date will be the date of the qualified event.

Note: The IRS allows a maximum of 31 days (from the qualifying event) for a special enrollment period. By day 32, you've missed your opportunity to make a change.

Preventive Care Services*

An ounce of *prevention* is worth a pound of cure.

Getting preventive care is one of the most important steps you can take to manage your health. Routine preventive care can identify and address risk factors before they lead to illness. When illness is prevented, it helps reduce healthcare costs.

The following is a list of the routine, preventive services that, if obtained in-network, are covered at 100% with NO COST SHARE as long as the provider submits the claim as routine. If submitted with a medical diagnosis, the claim will be subject to cost sharing, (i.e. deductible, co-pay, and/or co-insurance). The federal Affordable Care Act (ACA) includes a requirement that the preventive services listed below must be covered without the enrollee having to pay a copayment or co-insurance or meet a deductible.

Child Preventive Care

Preventive Physical Exams and Screening Tests

- Behavioral counseling to prevent skin cancer
- Behavioral counseling to promote a healthy diet
- Blood pressure screening
- Cholesterol and lipid-level screening
- Dental-caries prevention
- Depression screening
- Developmental and behavioral assessments
- Hearing screening for newborns
- Iron deficiency anemia screening and iron supplementation
- Lead exposure screening
- Newborn gonorrhea prophylaxis
- Newborn screenings, including sickle cell anemia
- Screening and behavioral counseling related to tobacco and drug use
- Screening and counseling for obesity
- Screening and counseling for sexually transmitted infections
- Screenings for inheritable diseases in newborns
- Tuberculosis screening
- Vision screening

Immunizations (Vaccines)

- Diphtheria, Tetanus, Pertussis (DTaP, Tdap)
- Haemophilus influenza type B (Hib)
- Hepatitis A (HepA) and Hepatitis B (HepB)
- Human Papillomavirus (HPV) Influenza (flu shot) (IIV, LAIV)
- Measles, Mumps, Rubella (MMR)
- Meningococcal (MCV)
- Pneumococcal (pneumonia) (PCV, PPSV)
- Polio (IPV)
- Rotavirus (RV)
- Varicella (chicken pox) (VAR)

Prescription Drugs

- Fluoride (age 0 to 6 years)

Iron (age 0 to 12 months)

Adult Preventive Care

Preventive Physical Exams and Screening Tests

- Abdominal aortic aneurysm screening (males age 65 to 75)
- Blood pressure screening
- Cholesterol and lipid level screening
- Colorectal cancer screening test, flexible sigmoidoscopy or colonoscopy (age 40 to 75)
- Depression screening
- Diabetes screening
- Hepatitis C screening if at high risk (or one-time screening for adults born 1945 to 1965)
- HIV screening
- Screening and counseling for sexually transmitted infections

Immunizations (Vaccines)

- Hepatitis A (HepA) and Hepatitis B (HepB)
- Herpes Zoster (shingles) (HZV)
- Human Papillomavirus (HPV)
- Influenza (flu shot) (IIV, LAIV)
- Measles, Mumps, Rubella (MMR) Meningococcal (MCV, MPSV)
- Pneumococcal (pneumonia) (PCV, PPSV)
- Tetanus, Diphtheria, Pertussis (Td, Tdap)

Preventive Care Services (cont.)

Women's Services

- Breast and ovarian cancer susceptibility screening, counseling and testing (including BRCA testing)
- Breast cancer screening (mammogram)
- Breast feeding counseling and rental of breast pumps and supplies up to the purchase price
- Bone density test to screen for osteoporosis (one every 24 months for age 50 and older)
- Cervical cancer screening (Pap test)
- Chlamydia screening
- Discussion of chemoprevention with women at high risk for breast cancer
- FDA-approved contraception methods and counseling for women, including sterilization
- HPV DNA testing
- Lactation classes (up to 20 visits)
- Pregnancy screenings (including hepatitis, asymptomatic bacteriuria, Rh incompatibility, syphilis, gonorrhea, chlamydia, iron-deficiency anemia, alcohol misuse, tobacco use, HIV, gestational diabetes)
- Prenatal services
- Primary-care intervention to promote breastfeeding
- Screening and counseling for interpersonal and domestic violence
- Well-woman visits (up to three visits)

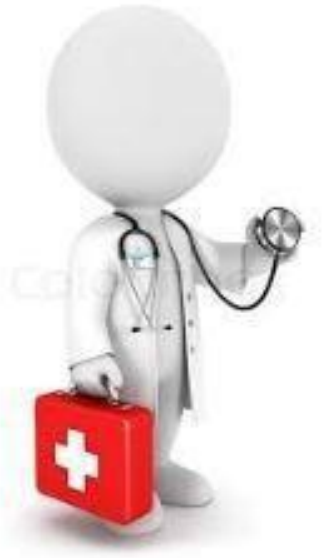
Counseling and Education Interventions

- Behavioral counseling to prevent skin cancer
- Behavioral counseling to promote a healthy diet
- Counseling related to aspirin use for the prevention of cardiovascular disease
- Prevention of falls in older adults
- Screening and behavioral counseling to reduce alcohol abuse
- Screening and behavioral counseling related to tobacco use
- Screening and nutritional counseling for obesity (up to four visits; additional visits must be pre-approved)

Prescription Drugs

- Aspirin (males age 45 to 79, females age 55 to 79)
- Colonoscopy preparations (age 40 to 75)
- Folic acid (females only)
- Medication to reduce risk of primary breast cancer in women
- Smoking cessation aids
- Vitamin D (age 65 and older)
- Women's contraceptives

* Preventive care benefits are subject to change.



Schedule of Medical Benefits
PPO Health Care Plan

Service	In-Network	Non-Network
Deductible	$500 single /$1,000 family	$500 single /$1,000 family
Maximum Out-of-Pocket (MOOP) Medical and Prescription Drug	$4,000 single/$8,000 family Incl. coinsurance & deductible	$4,800 single/$9,600 family Incl. coinsurance & deductible
Physician Charges		
Physician Office Visits	$25 Copay	80% UCR**
On-Demand, Virtual Telehealth Services	$25 Copay	80% UCR**
Specialist Office Visits	$35 Copay	80% UCR**
Urgent Care Provider Office Visit	$75 Copay	80% UCR**
Preventive Care	100%	100% UCR**
In Patient		
Anesthesia	80%*	80% UCR**
Consultations	80%*	80% UCR**
Newborn Care	80%*	80% UCR**
Institutional Services *(precertification is required for non-Emergency Services)*	80%*	60% UCR**
Physical Medicine and Rehabilitation	80%*	80% UCR**
Professional Services	80%*	80% UCR**
Skilled Nursing Facility	80%*	80% UCR**
Surgical Services	80%*	80% UCR**
Out-Patient Services		
Allergy Testing	80%*	80% UCR**
Diagnostic Imaging/Lab/Medical Tests/X-ray	80%*	80% UCR**
Allergy Treatment	80%*	80% UCR**
Home Health Care	80%*	80% UCR**
Pre-Admission Testing	80%*	60% facility / 80% professional UCR**
Surgical Services *(Including: anesthesia, assistant surgeon and surgery professional)*	80%*	80% UCR**
Surgery Facility	80%*	60% UCR**
Out-Patient Therapy		
Cardiac Rehabilitation	80%*	60% facility / 80% professional UCR**
Chemotherapy & Radiation Therapy	80%*	60% facility / 80% professional UCR**
Chiropractic	80%*	80% UCR **
Dialysis Therapy	80%*	60% UCR **
Hyperbaric Therapy	80%*	60% UCR **
Occupational, Physical & Speech Therapy	80%*	60% facility / 80% professional UCR **

Schedule of Medical Benefits Continued
PPO Health Care Plan

Service	In-Network	Non-Network
Mental Health, Alcohol/Substance Abuse		
Inpatient/Outpatient		
Facility	80%*	60% UCR**
Physician	80%*	80% UCR**
Psychotherapy-Office	80%*	80% UCR**
Psychotherapy-Outpatient		
Facility	80%*	60% UCR**
Physician	80%*	80% UCR**
Additional Services		
Ambulance	80%*	80% UCR**
Attention Deficit Disorder (ADHD)	Benefits are paid based on services rendered	Benefits are paid based on services rendered
Autism Spectrum Disorders, including Applied Behavior Analysis (ABA)	Benefits are paid based on services rendered	Benefits are paid based on services rendered
Clinical Trial	Benefits are paid based on services rendered	Benefits are paid based on services rendered
Diabetic Education & Training & Medical Nutritional Therapy Other than required by PPACA	80%*	60% UCR**
Durable Medical Equipment	80%*	80% UCR**
Genetic Testing & Counseling *(note: benefits required by PPACA will be payable as shown under "Health Care Reform Preventative Benefits")*	80%*	Not Covered
Hospice	80%*	80% UCR**
Infertility Testing *(Treatment is not covered)*	80%*	60% UCR**
Medical Supplies	80%*	60% UCR**
Organ Transplant	80%*	60% facility / 80% professional UCR**
Private Duty Nursing	80%*	60% UCR**
Sleep Disorders	Benefits are paid based on services rendered	Benefits are paid based on services rendered
Temporomandibular Joint (TMJ) Dysfunction	Benefits are paid based on services rendered	Benefits are paid based on services rendered
Hearing Aid (*1 pair every 3 years to a maximum of $2,200 per pair or $1,100 per hearing aid*)	100% no Deductible	100% UCR**
Pre-certification required for all Inpatient Admissions, Skilled Nursing Facility, Private Duty Nursing, Home Health Care, Hospice Care. Refer to your booklet for procedures that require pre-authorization.		

**** Subject to deductible and OOP limit. After that, Plan pays 100%***
***** Subject to deductible and OOP limit. After that, Plan pays 100% of UCR***
Payments to non-network providers based on UCR (Usual, Customary, Reasonable) sometimes called R&C (Reasonable & Customary) criteria.

IMPORTANT: This table is a partial listing of the benefits and provisions for the in-network services under the **Medical Mutual of Ohio** network. Please refer to your Summary Plan Document (SPD) or call Medical Mutual of Ohio at 1-800-382-5729 for more details.

REMINDER: The benefits of each insurance plan are highest when you use a network provider!

Rx Benefits with True RX	
Your prescriptions can be provided one of three ways: Retail pharmacy (includes most local pharmacies), Any in network pharmacy (up to 90-day fill at select pharmacies), and Home Delivery	
Retail 30-Day	
Tier 1 Generic	$5 copay
Tier 2 Brand	$25 copay
Mail 90-Day	
Tier 1 Generic	$10 copay
Tier 2 Preferred	$45 copay

IMPORTANT: Some prescription drugs are subject to quantity limits or may require prior authorization from True RX.

Review the True RX Pharmacy Network and Formulary Drug List at www.starkcountyohio.gov/human-resources/benefits or www.truerx.com/formulary for specific prescription-drug details. **The Formulary Drug List is subject to change.**

Home Delivery Service – Convenient and Easy to Use:

True Rx offers patients the convenience of a 90-day supply of medications delivered right to your door through our mail order pharmacy, WB Rx Express.

Ordering Your 90-Supply is Easy

Create an Online WB Rx Express Account

- Go to wbrxexpress.com and click "Get Started".
- Use the form to enter your name, address, phone number, email address, message (optional) and click the red Submit button.
- WB Rx Express will contact you within two business days to verify your account and medication information.

Ordering New or Transferred Prescriptions

- Ask your doctor to send your prescription to WB Rx Express by electronic prescribing, phone, fax or mail. Remember to set up your online account for refill convenience.

WB Rx Express
1998 State Street
Washington, IN 47501
Phone: 833-391-0126
Fax: 855-899-3925

Ordering Refills

Once your prescription has been received by WB Rx Express, you have three convenient ways to request refills.

- When allowed, WB Rx Express will automatically enroll you into an auto refill program. This program is designed to ensure you do not miss any doses with the convenience of receiving your medications on schedule in the mail.
- Refills may be ordered by phone by calling 833-391-0126.
- Download the RxLocal app and refill prescriptions from your phone.

About RxLocal

- To get started, download "RxLocal" from the App Store or Google Play. You will need a WB Rx Express prescription number. The prescription number is in the upper left-hand corner of the label on your medication container.
- Select medication(s) for refill and deactivate medication(s) you are no longer taking.
- Receive notifications when your medication is ready to be filled. You will be prompted to confirm your medication, and a tracking number will be provided once it has been fully processed.
- See the date the supply ends from your previous fill. For your safety, refill orders placed too early cannot be filled and may be put on hold until the earliest fillable date.

Specialty Care for Specialty Patients

We are excited to announce a new program, SHARx, that is provided to employees who are enrolled in our medical plan. The SHARx program was created to help source specialty medications at a reduced cost. With the assistance from the SHARx program, members typically have reduced out of pocket costs for their specialty medications each month. Providing the SHARx program means that all specialty medications are no longer covered when using your insurance card at your specialty pharmacy.

What is SHARx?
SHARx is an advocacy solution provided by the County. This program was created to extend advocacy program benefits to employees like you. Their role is to help facilitate the advocacy process for each eligible member of the County's health plan and provide access for all specialty medications.

What is considered a Specialty Prescription?
Any medication that is high complexity, high touch and usually over $1000 for a 30-day supply is included under the specialty medication designation. These would include Actemra, Advate, Aubagio, Avastin, Benlysta, Betaseron, Botox, Cellcept, Cimzia, Copaxone, Cosentyx, Eloctate, Enbrel, Entyvio, Epclusa, Eylea, Fasenra, Forteo, Gammagard, Genotropin, Gilenya, Glatopa, Harvoni, HP Acthar, Hizentra, Humatrope, Humira, Imbruvica, Inflectra, Jakafi, Kisqali, Lupron Depot, Mekinist, Ocrevus, Omnitrope, Orencia, Otezla, Pomalyst, Pulmozyme, Rebif, Remicade, Renvoq, Revlimid, Simponi, Skyrizi, Sprycel, Stelara, Taltz, Tecfidera, Trikafta, Tysabri, Vumerity, Xeljanz, Xolair, and MANY, MANY More!!

What happens if I don't enroll in the SHARx program?
Your specialty medication will no longer be covered by the County's pharmacy benefit plan.

How will I receive my prescriptions that are not specialty medications?
You will continue to use your same pharmacy for acute and non-specialty maintenance medications. You are welcome to see if the SHARx program can save you money on maintenance medications by visiting www.sharxplan.com/generics. Often you can receive a year's supply of maintenance medications for less than you would pay over the course of a year using your insurance copays. Use coupon code SHARx5 for $5 off your first order.

Superior Dental Benefits

Can I choose any dentist?
Yes. Your dental plan lets you choose any licensed dentist for services, but you may pay more for a service if you visit a dentist or specialist who does not participate in the SDC network. By staying in the network, you can pay less out of pocket for your dental care and avoid unexpected out-of- network balance billing, which is when an out-of-network dental provider bills for the difference between their fee for a service and our reimbursement amount.

What is an in-network dentist?
An in-network or participating dentist is a general dentist or specialist who has agreed to accept negotiated fees as payment in full for covered services provided to plan members.

How do I find an in-network dentist?
SDC offers one of the largest dental networks in the United States. Find a participating dentist or specialist near you with our Find-A-Dentist search tool at SuperiorDental.com.

If my dentist is not a participating network provider, how can they join the network?
If your dentist or specialist does not currently participate in SDC's network, you can refer them to us for network recruiting by completing our Dentist Referral Form at SuperiorDental.com/find-a- dentist or calling 1-800-801-4915. You are also encouraged to ask your dentist to consider joining SDC's network.

Is there a waiting period before I can get dental services once I'm enrolled?
No. There are no waiting periods once you enroll in an SDC dental plan. You can use these services as soon as your coverage begins.

What tools and resources are available to me?
SDC makes it easy to manage your dental plan. Our online member portal, Superior Direct Connect, and our SDC mobile app offer convenient access to your ID card, summary of benefits, claim status, Explanation of Benefits (EOBs) and more. We also offer an Interactive Voice Response (IVR) telephone system available 24/7. Simply call 1-800-801-4915 to verify enrollment, check claim status or order new ID cards, or choose to speak to an SDC Member Services representative during business hours (Monday–Friday, 7:30am–5:00pm EST).

Can I find out what my out-of-pocket expenses will be before receiving a service?
Yes. A pre-determination of benefits will tell you what your out-of-pocket expenses are going to be and what your plan will cover for a specific treatment based on information provided by your dentist. You can ask your dentist to request a pre-determination from SDC for any treatment or service before it is performed. A pre-determination is suggested when a proposed treatment plan exceeds $400 or includes periodontal treatment. Once your dentist submits a pre-determination form, it will be reviewed by our dental consultants (who are licensed dentists), estimated benefits will be determined, and a document with this information will be mailed to both you and your dentist. Please note that this benefit verification does not guarantee payment. The amount payable is subject to all the contract limitations effective at the time the services are rendered.

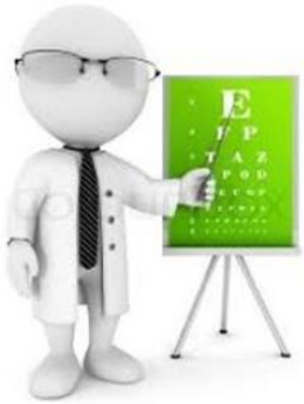
Superior Dental Care®
A Medical Mutual® Company

		Plan Pays	
		In-Network	Non-Network
Benefits	Benefit Period Deductible	None	None
	Benefit Period Maximum (per member)	$1,500	$1,250
	Reimbursement Basis	Network Allowable	90th Percentile
	Preventive Services		
	Oral Exams (two per benefit period)	100%	100%
	Prophylaxis (cleaning) (two per benefit period; two additional prophylaxes are payable per benefit year for individuals with a documented history of periodontal disease)	100%	100%
	Topical Application of Fluoride (twice per benefit period for children under age 14)	100%	100%
	Bitewing X-rays (four per benefit period)	100%	100%
	Full Mouth X-rays or Panoramic Survey (once in three years)	100%	100%
	Periapical X-ray (three per benefit period)	100%	100%
	Minor Emergency Treatment temporary relief of pain, bleeding or swelling	100%	100%
	Space Maintainers (once per lifetime for children under 14)		
	Sealants posterior permanent molars only (once per four years per tooth for children under the age of 16)	100%	100%
	Brush Biopsy to detect oral cancer	100%	100%
	Basic Services		
	Composite or Amalgam Fillings (once per tooth per surface every two years)	80% after deductible	80% after deductible
	Minor Restorative Services	80% after deductible	80% after deductible
	Periodontal Services	80% after deductible	80% after deductible
	Extractions	80% after deductible	80% after deductible
	Endodontics/Pulp Services (once every two years per tooth)	80% after deductible	80% after deductible
	Oral Surgery Services	80% after deductible	80% after deductible
	General Anesthesia or IV Sedation in conjunction with oral surgery or surgical extractions	80% after deductible	80% after deductible
	Major Services		
	Crowns and Onlays (replaceable after five years in place)	50% after deductible	50% after deductible
	Bridges pontics and retainer units (replaceable after five years in place)	50% after deductible	50% after deductible
	Partial and Complete Dentures (replaceable after five years in place)	50% after deductible	50% after deductible
	Relines (once in two years)	50% after deductible	50% after deductible
	Repairs (once in two years)	50% after deductible	50% after deductible
	Implants (once every five years per tooth)	50% after deductible	50% after deductible
	TMD Treatment – treatment of the disorder of the temporomandibular joint, including related films	50% after deductible	50% after deductible
	Orthodontia		
	Orthodontics (no age limit)	50%	50%
	Orthodontics Lifetime Maximum (per member)	$1,500	$1,500

Out-of-network reimbursement is based on the Usual, Reasonable and Customary (UCR) allowances.

Any out-of-network service may be subject to a “balance bill” for any amount that the dentist’s charge exceeds the allowable amount for an eligible service.

To review the complete list of covered services, limitations and exclusions, refer to SDC’s Evidence of Coverage and the Schedule of Benefits associated with the plan number above.



The County has selected EyeMed as your vision wellness program. This plan allows you to improve your health through a routine eye exam, while saving you money on your eye care purchases.

You may seek treatment from any provider, but you save the most money by using the EyeMed **Select Network** providers. Refer to the EyeMed summary of benefits for a complete review of the network and non-network benefit levels for each plan.

EyeMed Vision Services	Member Cost In-Network	Out of Network Reimbursement
Frequency		
Exam	12 months	12 months
Lens	12 months	12 months
Frames	24 months	24 months
Exam Co-pay	$10	Up to $35
Lens Co-pay		
Single	$15	Up to $25
Bifocal	$15	Up to $40
Trifocal	$15	Up to $55
Standard Progressive	$80	Up to $55
Premium Progressive **	$80, 80% of charge less $120 Allowance **See note**	Up to $55
Frame Allowance	$0 Copay $150 Allowance plus 20% off balance over $150	Up to $45
Contact Lenses	$0 Copay $150 Allowance plus 15% off balance over $150	Up to $105
Value Added Features		
Eye Care Supplies	Receive 20% off retail price for eye care supplies like cleaning cloths and solutions purchased at network providers (not valid on doctor's services or contact lenses).	
Lasik	Save 15% off the retail price or 5% off the promotional price for Lasik or PRK procedures	
Replacement Contact Lenses	Visit www.eyemedcontacts.com to order replacement contact lenses for shipment to your home at less than retail price	

**** Note:** Premium Progressive Lenses include different tiers based on the different qualities of the peripheral vision with the highest (tier 4) reimbursed at a copay, plus 80% of charge, less a $120 allowance. Refer to the EyeMed Summary of Benefits for details or contact EyeMed at 1-866-800-5457 or www.eyemed.com.

Group Term Life Insurance

Participants in the Health Plan are enrolled for $10,000 of Basic Life and AD&D at a cost of $1.20/month.

Supplemental Life and AD&D Insurance

You can purchase Supplemental Life and AD&D Insurance in the amount(s) of $10,000, $25,000, $50,000, $75,000, $100,000, $200,000 or $300,000. When you are first eligible, you may elect up to $100,000 without providing evidence of insurability. Amounts over $100,000 are subject to a health questionnaire and carrier approval. At Open Enrollment, employees currently enrolled for Supplemental may increase coverage by one level up to $100,000 without providing evidence of insurability. Employees who were previously eligible and declined may elect coverage at the $10,000 level. Monthly coverage levels and premiums for Supplemental Life and AD&D are shown on the Enrollment Form at the link below. Our group policy with The Hartford also includes options for continuation plans after you are no longer a full-time County employee. Continuation options are described in the Hartford Continuation Packet at the link below.

Coverage Amount	Monthly Cost
$10,000	$4.05
$25,000	$10.13
$50,000	$20.25
$75,000	$30.38
$100,000	$40.50
$200,000	$81.00
$300,000	$121.50

Hartford Life Booklet

Hartford Basic Life Enrollment Form

Hartford Supplemental Life Enrollment Form

Hartford Beneficiary Change Form

Hartford Continuation Packet

Employee Assistance Program (EAP)

Please share this information with your family. Assure them the program is strictly confidential.

Call the EAP anytime you need assistance.

Contact **Life Services EAP** 24/7 at: 1-800-822-4847

The County offers employees and their immediate family the benefit of the Life Services Employee Assistance Program. By offering this program, we are making an investment in your well-being. We strive to be supportive of your emotional, physical and social needs at home and at work, which ultimately bring about a healthier and more balanced life for you and your family.

Available to you and your dependents are the services of qualified professionals who can assist in dealing with a wide variety of issues and concerns, such as:

Stress	**Family/Relationship**	**Fitness**
Diet/Nutrition	**Drug/Alcohol abuse**	**Geriatric concerns**
Marital issues	**Finances/budgeting**	**Legal issues**
Lifestyle choices	**Adolescent concerns**	**Depression/Anxiety**
Retirement concerns	**Smoking Cessation**	**Grief/Loss**

EAP Services adhere to and follow strict guidelines to ensure your privacy and confidentiality. The only aggregated statistical information shared includes data such as the number of cases and hours of service provided; no individual names or identifying information is ever released.

The County pays the full cost of the EAP program for employees and dependent family members! Our EAP program covers up to six sessions per issue. Whether it's counseling, advice, referrals or general resources you're looking for, Life Services will help.

Life Services EAP services are accessible to you and your dependents 24- hours a day and seven days a week. Request services by phone (1-800-822-4847)

LifeServices EAP
Personal Service Every Time

AMERIFLEX is the County's administrator for our Flexible Savings Accounts (FSA – Medical and Dependent Care).An FSA is a personal reimbursement account that you use to pay for qualified expenses incurred during the plan year. Amounts you put into your FSA are deducted from your income before federal and state taxes are withheld, which reduces your overall taxable income. There are two types of FSAs offered. You may elect to deposit part of your before-tax income into one or both types of FSA accounts.

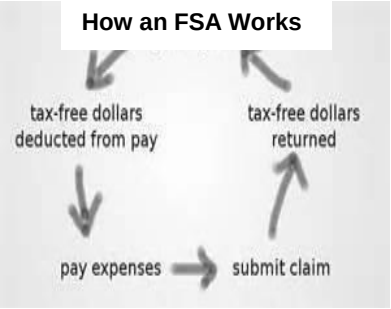
Medical FSA

A Medical FSA allows you to pay for your family's out-of-pocket medical, dental and prescription-drug expenses. **In 2025, the maximum you may deposit into a Medical FSA is $3,300.** The FSA plan year runs from January 1 through December 31. The Medical FSA plan includes a **$660 Rollover Feature.** This means that if you don't use all your funds, you may rollover up to $640 of the prior plan year funds into the new plan year. If your account exceeds $660, you'll have 90 days from the end of the plan year to submit claims for reimbursement. Rollover funds will be available late April/early May following the end of the prior plan year.

An Example

Jean's family will have expenses for office visits and prescription copays that will be at least $400. In addition, her spouse plans to get new eyeglasses that cost $220, and payments on her son's braces will cost $1,200 this year. So, Jean will have at least $1,820 in unreimbursed medical expenses in the coming year. Here's how using a Medical FSA can help save taxes for Jean and her family:

	With a Medical FSA	Without the FSA
Jean's gross annual pay Less pre-tax FSA deduction	$35,000 - 1,820	$35,000 - 0
Taxable income	**$33,180**	**$35,000**
Less income taxes	- $3,593	- $3,812
Net Pay	**$29,587**	**$31,188**
Plus FSA reimbursement	+ 1,820	
Disposable Income	**$31,407**	**$31,188**



Jean's net pay is lower with the FSA. But don't forget, when she turns in a qualified expense claim that FSA money will be there for her tax free. That adds $219 to Jean's disposable income by the end of the year! Your tax savings will depend on your personal situation and individual tax bracket.

Dependent Care FSA

A Dependent Care FSA lets you use pre-tax dollars to pay for eligible expenses related to care for your qualified dependents so you can work, or if you're married, for your spouse to work, look for work or attend school full time. Dependents include your:

- child under age 13
- disabled spouse
- elderly parent
- or other dependent who is physically or mentally incapable of self-care

The maximum annual deduction for the Dependent Care FSA is $5,000 unless you are married but file taxes separately. In this case, the maximum deduction is $2,500. All persons and organizations that provide dependent care must be properly identified and provide their name, address, and taxpayer identification number.

Colonial Voluntary Benefits

You may choose to cover yourself with an individual policy to protect your income, supplement your medical plan, and help to protect what is yours:

Individual Policies

- Short-Term Disability benefit
- Universal Life
- Term Life
- Accident Insurance
- Cancer Insurance
- Specified-Disease benefit

For more information, contact a Colonial representative at 1-800-845-7330.

Please remember that Colonial Voluntary Benefits are individual insurance policies. Because they are not one of the County's group policies, you must enroll directly with Colonial either when you are first hired, or during the Colonial Open Enrollment period.

As a convenience for employees, the County collects your post-tax premiums by payroll deduction and sends funds to Colonial on your behalf. Policies are portable at the same premium.

For information regarding Colonial contact:

April Bryce, Agency Sales Representative
April.Bryce@ColonialLifeSales.com
(216) 409-0241

Medicare Part D Creditable Coverage Notice

This notice has information about your current prescription drug coverage with the Board of Stark County Commissioners and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

It has been determined that the prescription drug coverage offered by County group health plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage.

Because your existing coverage, is on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 through December 7.

However, if you lose creditable prescription drug coverage, through no fault of your own, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What happens To Your Current Coverage If You Decide to Join a Medicare Drug Plan?
If you decide to join a Medicare drug plan, your group's health plan for prescription drug coverage will not be affected. If you decide to join a Medicare drug plan and drop your group's health plan prescription-drug coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join a Medicare Drug Plan?
You should also know that if you drop or lose your coverage with the County group health plan and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen (19) months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) if you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription-Drug Coverage
Contact the Benefits Department for further information at 330-451-7905.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the Board of Stark County Commissioners changes. You also may request a copy of this notice at anytime.

For More Detailed Information About Your Options Under Medicare Prescription-Drug Coverage
Consult the "Medicare and You" handbook. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

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

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

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

Date:	January 1, 2025
Name of Entity/Sender:	Board of Stark County Commissioners
Contact:	Benefits Department
Address:	110 Central Plaza South, Suite 101 Canton, Ohio 44702
Phone Number:	330-451-7905

Women's Health and Cancer Rights Act (WHCRA)
The Women's Health and Cancer Rights Act (WHCRA) provides protections for individuals who elect breast reconstruction after a mastectomy. Under WHCRA, group health plans offering mastectomy coverage must also provide coverage for certain services relating to the mastectomy, in a manner determined in consultation with the attending physician and the patient. Required coverage includes all stages of reconstruction of the other breast to produce a symmetrical appearance, prostheses and treatment of physical complications of the mastectomy, including lymphedema.

Medicaid and the Child Health Insurance Program (CHIP)
If you or your dependent(s) are not currently enrolled in Medicaid or CHIP and you think your dependents might be eligible, you can contact the Ohio Medicaid or CHIP office or call 1-877-KIDS-NOW or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependent(s) are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit your dependent(s) to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. **You have 60 days to request coverage after it is determined you are eligible for premium assistance.**

Patient Protection and Affordable Care Act (PPACA) / Health Care Reform and Marketplace or State-Based Exchanges: Under the PPACA (also known as the Affordable Care Act), a federally-operated Exchange, or Marketplace, has been established for individuals and business to purchase health insurance. Individuals who qualify for Medicaid, federal subsidies, or tax credits may also use the Marketplace to obtain health coverage. Marketplace plans are operational in the State of Ohio as of January 1, 2014. Visit: **www.Healthcare.gov** for more information.

Impact: *The Board of Stark County Commissioners provides health insurance that meets the minimum value and affordability aspects of the PPACA. Therefore, if you are eligible for benefits through the County, you do not qualify for federal subsidies or tax credits through Marketplace enrollment.*

Uniform Summary of Benefits Coverage (SBC): IRS and the Department of Labor and Health and Human Services have identified the standards for a uniform explanation of coverage requirement. Benefit summaries may include the following provisions: Uniform definitions of insurance and medical terms, premium and cost sharing provisions, description of plan coverage, plan contact information, etc. The SBCs for the health benefits plans offered by the *Board of Stark County Commissioners* are available on the Employee Benefits Website: **Stark County Employee Benefits**

Continuation Coverage under COBRA:

COBRA continuation coverage is a continuation of employee health benefits coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed earlier in this open enrollment guide. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

Reporting Employer-Provided Health Coverage in Form W-2:
The Affordable Care Act requires employers to report the cost of coverage under an employer-sponsored group health plan on an employee's Form W-2, Wage and Tax Statement, in Box 12, using Code DD.

In general, the amount reported includes both the portion paid by the employer and the portion paid by the employee. This reporting is required, not only to show employees the value of their health care benefits so they can be more informed consumers, but for the purpose of reporting our health care enrollment compliance.

HIPAA Notice of Privacy Practices - Our Commitment Regarding Your Personal Health Information
The Board of Stark County Commissioners is committed to maintaining and protecting the confidentiality of our employees' personal health information. Each health plan entity is required by federal and state law to protect the privacy of your individually identifiable health information and other plan information, known as Protected Health Information (PHI). You'll receive Privacy Notices from each responsible entity after your initial enrollment and periodically as may be necessary.

Patient Protection Disclosure
The Board of Stark County Commissioners Health Benefits plan will continue to **not require** employees to designate a primary-care provider for themselves or their dependents. All members are encouraged to use providers who participate in our networks and who are available to accept you or your covered dependents as patients.

As has been our practice, you do not need prior authorization from our plan or from any other person (including a primary-care provider) in order to obtain access to obstetrical or gynecological care from a healthcare professional in our network who specializes in obstetrics or gynecology. The same is true of other specialties such as orthopedics.

The healthcare provider however, may be required to comply with certain procedures, such as obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

Disclaimer

The information in this Enrollment Guide is presented for illustrative purposes. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Guide and the actual plan documents, the actual plan documents will prevail. If you have any questions about your Guide, contact the Benefits Department at 330-451-7905 or e-mail at merichardson@starkcountyohio.gov.

TERMINOLOGY

Allowed Amount	The maximum amount a plan will pay for a covered health care service. May also be called “eligible expense,” “contracted rate” or “negotiated rate.”
Balance Billing	When a non-network provider bills you for the difference between the provider’s charge and the allowed amount. For example, if the provider’s charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred (in-network) provider may not balance bill you for covered services.
Coinsurance	The percentage of costs of a covered healthcare service you pay (20%, for example) after you've paid your deductible.
Copay (Copayment)	A fixed amount ($20, for example) you pay for a covered healthcare service, typically a physician office, urgent care or Emergency Room visit. It can vary for different services within the same plan, like prescription drugs and visits to specialists. The copay is independent of the deductible.
Deductible	The amount you pay for covered health care services before your insurance plan starts to pay. With a $700 deductible, for example, you pay the first $700 of covered services subject to a deductible. After you pay your deductible, you usually pay only a copayment or coinsurance for covered services and the County (through its claims administrator) pays the rest.
Embedded Deductible (PPO Plan)	One person must meet the single deductible; a combination of two or more can meet a family deductible.
Maximum out of pocket (MOOP)	The maximum amount you pay each plan year for all covered services combined that includes the deductible and coinsurance, and all copays including the Rx copays. Once met, the plan reimburses 100% for the covered services for the remainder of that year. The MOOP does not include your semi-monthly contributions, balance-billed charges, or any healthcare services not covered.
Medical Emergency	n acute illness, injury, symptom or medical condition that poses an immediate risk to a person's limb, life or long-term health.
Prior Authorization	Certain services, treatment plan, prescription drugs and durable medical equipment require prior approval from our plan administrators, to ensure they are medically necessary. Also called preauthorization.
Preferred Provider Organization (PPO)	A type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. You pay less if you use providers that belong to the plan’s network. You can use doctors, hospitals, and providers outside of the network for an additional cost.
Network	The facilities, providers and suppliers your health plan has contracted with to provide health care services. You’ll pay more to receive services from a non-network provider.

Important Contacts

Stark County Commissioners
Benefits Department
110 Central Plaza South, Suite 101
Canton, Ohio 44702

Megan Richardson
Benefits Administrator
Phone: **(330) 451-7905**
Fax: **(330) 451-7906**

Medical Mutual of Ohio Member Services
1-800-382-5729

True RX Customer Care
1-866-921-4047

Superior Dental Customer Service
1-800-801-4915

EyeMed Customer Service
1-866-723-0514

Hartford Customer Service
1-800-523-2233

Colonial Life
1-800-325-4368

LifeServices EAP
1-800-822-4847

OPERS
1-800-222-7377